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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF TEXAS

— — —

THE HONORABLE GEORGE C. HANKS, JR., JUDGE PRESIDING

USA, No. 4:21-CR-00009-1

Plaintiff,

vs.

ROBERT T. BROCKMAN,

Defendant.

COMPETENCY HEARING -- DAY 2 AM SESSION

OFFICIAL REPORTER'S TRANSCRIPT OF PROCEEDINGS

Houston, Texas

TUESDAY, NOVEMBER 16, 2021

APPEARANCES:

For the Plaintiff: COREY J. SMITH, DOJ

CHRISTOPHER MAGNANI, DOJ

LEE F. LANGSTON, DOJ.

BORIS BOURGET, DOJ

For the Defendant: JASON S. VARNADO, ESQ., Attorney at Law

COLLEN O'CONNOR, ESQ., Attorney at Law

JAMES P. LOONAM, ESQ., Attorney at Law

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Proceedings recorded by mechanical stenography.
Transcript produced by Reporter on computer.

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PROCEEDINGS

(The following proceedings held electronically.)

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TUESDAY, NOVEMBER 16, 2021 -- 9:11 A.M.

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THE COURT: Morning, everyone. We're continuing the competency hearing in this matter. If you would like to continue examining the witness.

ROBERT DENNEY,

(For the GOVERNMENT)

having previously been called as a Witness, and having already been duly and regularly sworn, continued to testify as follows:

DIRECT EXAMINATION RESUMED

BY MR. COREY SMITH:

Thank you, Your Honor.

Q. Dr. Denney, when we broke last night, you had conveyed your opinion to the Court that you believe that the Defendant is competent to stand trial in this case; do you recall that?

A. Yes, I do.

Q. And can you -- again, let's pick up where we left off. What do you base that opinion on?

A. Well, there's many things that I would have to list. One is, first of all, the neurocognitive

09:11:54 testing from the very beginning looks to be
09:12:00 disingenuous, so we cannot rely on that as
09:12:05 indicative of his true memory ability.
09:12:12 Mr. -- and basically but for the
09:12:17 memory concern, all other aspects of his -- well, I
09:12:22 probably should not say that. Mr. Brockman is a
09:12:27 very bright man pre-morbidly. For individuals who
09:12:32 are very bright, they have a cognitive reserve.
09:12:35 The -- there is evidence that he
09:12:40 has a neurodegenerative disease -- Parkinson's
09:12:46 disease for sure. Parkinson's disease has a long,
09:12:48 slow course. Rarely -- rarely does somebody
09:12:54 demonstrate significant, gross impairments in memory
09:12:59 and overall cognitive functioning until late in the
09:13:02 course of the disease.
09:13:06 There is also neuroimaging findings
09:13:10 to suggest Mr. Brockman, likely, has an Alzheimer's
09:13:14 disease process starting in his brain. Those
09:13:20 findings are rated as mild. Even when you compare
09:13:25 the FDG's first PET to the second PET, the change
09:13:29 was mild. Those findings indicate he would be in
09:13:36 the earliest stages of that disease process.
09:13:39 People his age, 80-year-olds, can
09:13:43 have positive beta-amyloid PET scans and be
09:13:50 cognitively normal and in the MCI stage. That's

09:13:53 where they're first starting to notice mild
09:13:56 cognitive difficulties, but it's not impairing daily
09:14:00 functioning in a significant way.
09:14:05 Consequently, those findings do not
09:14:08 suggest he would be severely impaired.
09:14:11 Additionally, the MRI volumetric studies, looking at
09:14:15 the parts of the brain that are specific to
09:14:16 Alzheimer's pathology, as that pathology progresses
09:14:22 and a person starts to have significant memory and
09:14:26 cognitive problems, um, those then correlate with
09:14:34 shrinkage of brain volume. The metric MRI studies
09:14:40 show his brain volume for the hippocampus and the
09:14:43 temporal lobes, in general, are within normal ranges
09:14:48 for his age.
09:14:48 Those findings communicate to me
09:14:51 that although Mr. Brockman has neurodegenerative
09:14:57 disease process, he's in the earliest stages of
09:15:00 those disease processes. Consequently, that
09:15:09 objective data does not correspond with the grossly
09:15:13 impaired neurocognitive test scores. The
09:15:17 explanation for that is validity findings. We
09:15:20 cannot rely on those tests data.
09:15:26 So in addition to that, the --
09:15:31 Dr. Park -- I mean Dr. Dietz and I, during the first
09:15:40 evaluation in October, went through -- or I led it.

I went through a structured interview on competency-specific issues, called the Competency Assessment Instrument. It asks questions about his understanding of the charges, his understanding of the roles of courtroom participants, his understanding as his own role as a defendant, his relationship, and his understanding of counsel and the role of counsel.

It also asks questions about his understanding of the consequences of the proceedings, how serious that is, what likely outcomes are. And Mr. Brockman demonstrated a reticence to discuss details of his case.

Q. If I can interrupt, Dr. Denney, would you like a bottled water?

A. I have one, thank you. But I'm getting there, yes.

Q. The test that you just mentioned, is there a score sheet you used when you were asking those questions of Mr. Brockman?

A. The first one, the Competency Assessment Instrument, there is no score sheet for that. It's a structured interview. Originally, it had a score sheet, but over the years forensic psychologists realized that score sheet doesn't amount to any

meaningful findings.

It's really more of a guide to make sure you are asking the right questions.

Q. Was there a test that you administered to Mr. Brockman that encompassed his competency -- his ability to understanding legal proceedings and assist his counsel?

A. Yes, both of the tests. I was describing the Competency Assessment Instrument, the first one done in May --

Q. Okay.

A. -- but I also administered another one called the ECST-R, or Evaluation of Competency to Stand Trial-Revised, ECST-R.

MR. COREY SMITH: With the Court's permission we have that score sheet, that test sheet. We would like to put it on the screen. This is from Dr. Denney's data that was shared with counsel.

THE COURT: Is this an exhibit?

MR. COREY SMITH: Marking it for identification as 119 at this time.

THE COURT: Okay.

MR. COREY SMITH:

Q. I thought it might be easier, Dr. Denney, to

explain this test to the Court if the sheet was in front of you.

A. Sure.

Q. While we're trying to get the technology working, why don't you explain this test, what you asked, and how Mr. Brockman did on this test for the Court?

A. Yes, this is a standardized, semi-structured interview that does have scoring criteria. It asks questions focused on the same types of things I was mentioning, his understanding of the charges against him, their consequences -- how serious they are, his understanding of courtroom participants, all of the primary players in the process of the criminal adjudicative process, and it also asks him questions about his thoughts, concerns, and ideas -- not only about the charges in his case, but also about counsel -- to ascertain whether he has much trust in counsel, whether he's able to rely on counsels' recommendations -- that sort of thing.

And so, the summary scores of it come down into three different categories. One is consulting with counsel. The other two deal with a factual understanding of his case, and also a rational understanding of his case.

09:19:39 **Q.** When did you administer this test to
09:19:41 Mr. Brockman?
09:19:42 **A.** It was -- it ended up being split over two
09:19:45 days, but it was in this -- this most recent October
09:19:48 of 2021.
09:19:50 **Q.** And in your opinion, did Mr. Brockman pass this
09:19:53 test?
09:19:54 **A.** Yes. Yeah, when looking at his actual answers
09:19:58 related to his case, none of his answers suggested
09:20:04 an abnormal understanding of his case. All of his
09:20:08 responses were consistent with the nature of the
09:20:11 case. He seemed to have a good awareness of it.
09:20:15 I will put a caveat in there that
09:20:17 he, again, was reticent to discuss many details
09:20:21 about his case, citing that he believed that would
09:20:23 be wrong for him to disclose much information about
09:20:26 his case. I believe he suggested it was at the
09:20:32 request of counsel that he shouldn't talk about his
09:20:34 case.
09:20:34 **Q.** And these responses by Mr. Brockman to this
09:20:38 test, in his score of the test, how does that inform
09:20:41 your opinion of his competency to stand trial in
09:20:43 this case?
09:20:46 **A.** Again, setting the issue of -- of severe
09:20:50 cognitive impairment aside, he demonstrated a

09:20:55 factual and rational understanding of the nature and
09:20:57 consequences of the proceedings against him, and he
09:21:01 appeared capable and motivated to cooperate with
09:21:04 counsel.
09:21:05 The scores all fell within the
09:21:09 normal range.
09:21:10 **Q.** I think we now have it. If you can describe to
09:21:15 the Court what we're looking at?
09:21:16 **A.** Sure. This is simply a summary. It's not the
09:21:19 test itself. It's a summary of the scores. What we
09:21:23 look at is the column over on the right side, which
09:21:27 is the competency scales.
09:21:32 The way this is scaled on this
09:21:34 graph is scores above 60 are of concern, that would
09:21:40 suggest possible moderate difficulties. I'll use
09:21:44 the word "Moderate" meaning relatively mild, but
09:21:48 starting to have some difficulty that would be of
09:21:50 concern.
09:21:52 Scores down below 60 are within the
09:21:55 normal limits, compared to competent individuals --
09:21:59 the norms that are based on this structured test.
09:22:02 **Q.** Are those numbers across the bottom on the
09:22:04 right the scores of Mr. Brockman?
09:22:06 **A.** Yeah, those are T-scores, translated based upon
09:22:10 norms. They graph out where I placed the X's. They

09:22:14 all fall within the perfectly reasonably competent
09:22:17 range.
09:22:17 **Q.** Could you briefly describe for the Court --
09:22:19 there's five numbers there -- I'm sorry, four
09:22:22 numbers there, 45, 44 -- what each one of
09:22:26 those signifies to you?
09:22:27 **A.** Yes. Sure. The first one, 45, corresponds
09:22:30 with the CWC, which stands for consulting with
09:22:34 counsel. The reason there's a zero down there --
09:22:37 the way this test works is when somebody says
09:22:41 something that suggests an impairment in that
09:22:43 reasoning or understanding ability, they gain
09:22:50 points. The more points on this, the more impaired
09:22:53 it is.
09:22:53 And he identified nothing in his
09:22:55 responses in those areas that I would consider to be
09:23:01 abnormal, or to meet the criteria for gaining
09:23:04 points. That's why it's a zero, which translates to
09:23:06 a T-45 in the normal range.
09:23:08 The next one is the FAC, which
09:23:12 would be a factual understanding of his case. His
09:23:20 score of one point -- there was one item on the test
09:23:23 where he did not respond with much detail. I
09:23:32 thought maybe there could be something behind that.
09:23:36 I don't know. Maybe a one instead of a zero, but

there was nothing blatantly abnormal about his response, it's just -- it wasn't very disclosing.

As a result, he got turned into a T-score of 40, which is about -- you know, normal range still. The next one is RAC, which deals more with rational understanding of his case. His responses in that regard also scored out to suggest no significant impairment whatsoever, which resulted in a T-score of 44.

The last column is a combination of the factual and rational scales to create a little summary scale of obviously factual and rational understanding. And his scores were normal on that as well.

Q. Now, yesterday you also were describing for the Court what you called validity testing. How do these validity tests work, and how do you administer them to -- in this case Mr. Brockman?

A. Well, let me start with the first part of that question, how do they work.

Q. Yes.

A. Because that is a long answer. I will try to keep it brief. These tests, designed to be validity tests, the purpose is to identify whether somebody is putting forth appropriate task engagement, which

09:25:04 means are they applying themselves to the task like
09:25:08 they're supposed to be with the intent of performing
09:25:12 at the best that they can.
09:25:14 They are designed to look difficult
09:25:18 to an average person, but in reality they're not
09:25:22 difficult. And they're -- and they're researched to
09:25:29 demonstrate that they're not particularly difficult
09:25:31 in various different pathological conditions. And
09:25:35 in that process, we develop cutoff scores.
09:25:39 So every validity test has a cutoff
09:25:43 scores -- and maybe there's multiple cutoff scores
09:25:47 depending on the clientele we're dealing with, like
09:25:50 many of these tests have to be adjusted a little bit
09:25:52 to deal with people who are older or who have
09:25:55 potential cognitive problems.
09:25:58 When you adjust those cutoff
09:26:01 scores, they are adjusted in a way so that you keep
09:26:03 the false positive rate low. You don't want a
09:26:11 validity test to wrongly say somebody is
09:26:14 exaggerating. So we keep the cutoff score at a
09:26:19 point that makes what's called the false-positive
09:26:22 rate very low. It's analogous to beyond a
09:26:26 reasonable doubt. You don't want to call somebody
09:26:28 exaggerating when they really aren't.
09:26:30 So we set that at a rate below .10,

09:26:34 meaning that it will be less than ten out of a
09:26:39 hundred would be called positive, on average. We
09:26:43 find that is the most accurate, diagnostically,
09:26:48 place to set the cutoff. So that's with one test,
09:26:51 but we don't just rely on one test. We include
09:26:55 multiple tests arranged throughout the other testing
09:26:59 in a random way so they're mixed in.
09:27:04 And we look at the number of
09:27:05 positive tests, not just a one-single test.
09:27:10 Although one-single test can be dispositive if it's
09:27:13 severe enough -- I mean, if it's so extreme, but we
09:27:18 typically look at a multiple set of these validity
09:27:21 tests, and they tell us whether the other cognitive
09:27:24 testing administered during the same evaluation can
09:27:29 be relied upon or not.
09:27:31 **Q.** So what does it mean when someone you are
09:27:34 testing fails a validity test?
09:27:36 **A.** That means the person went beyond the cutoff on
09:27:42 the test to suggest exaggeration.
09:27:47 **Q.** What does that mean, exaggeration? Is that the
09:27:50 same as malingering?
09:27:52 **A.** Well, in this context basically yes. Although
09:27:55 there's -- as I mentioned yesterday, there's a
09:27:58 little bit more reasoning that a clinician has to go
09:28:02 to get to malingering beyond exaggeration. You have

09:28:05 to determine that exaggeration is due to a
09:28:08 significant, secondary gain and was intentional.
09:28:12 **Q.** Now, you examined Mr. Brockman both in May and
09:28:15 in October; is that right?
09:28:17 **A.** Yes.
09:28:17 **Q.** And in both evaluations, did you use these
09:28:22 validity tests to evaluate Mr. Brockman?
09:28:24 **A.** Yes, I did.
09:28:25 **Q.** Did he fail any of these validity tests?
09:28:28 **A.** Yes, he did.
09:28:28 **Q.** Did he fail both in May and in October?
09:28:31 **A.** Yes, he did.
09:28:33 **Q.** Now, I know that some of these names get
09:28:35 somewhat technical, but how many validity tests, if
09:28:38 you can recall -- if you want to refer to your
09:28:40 reports in the binders right next to you, your
09:28:44 reports are pre-admitted as Exhibits 1 and 2 in the
09:28:48 white binders --
09:28:49 **A.** Can I look at my report in my folder?
09:28:50 **Q.** Yeah, you've got your report, or you can use
09:28:53 the exhibit in the binder. In the first evaluation
09:28:57 in May of 2021, how many validity tests did you use
09:29:01 to evaluate Mr. Brockman?
09:29:13 **A.** I believe there were five different validity
09:29:16 tests incorporated in the examination.

09:29:19 **Q.** In May?
09:29:19 **A.** In May of 2021, yes.
09:29:23 **Q.** Let me just backtrack just a little bit. Can
09:29:26 you explain to the Judge the difference between a
09:29:28 free-standing validity test and an embedded validity
09:29:32 test?
09:29:32 **A.** Yes, thank you. I think I mentioned this
09:29:35 briefly yesterday, but I was going a little fast.
09:29:39 Free-standing validity tests are tests that are
09:29:41 designed from the get-go to be a validity test.
09:29:47 They are independent, and you insert them into your
09:29:51 overall examination at various places in the test
09:29:56 battery -- not the same one. You only do one at a
09:30:00 time, you know, in one exam, but there's multiple
09:30:04 different free-standing ones.
09:30:06 The goal is to put at least two,
09:30:12 maybe three -- sometimes more -- in your battery,
09:30:15 depending on other issues. Now, the embedded
09:30:17 validity indicators are indicators that over time we
09:30:23 have learned that, and research has demonstrated
09:30:26 that within normal neurocognitive testing there are
09:30:30 oftentimes characteristics that are very rarely
09:30:39 failed by people who even have significant,
09:30:43 cognitive impairment.
09:30:45 And so those characteristics can be

09:30:47 used as an embedded validity indicator.
09:30:52 **Q.** So if I can direct your attention to Page 24 of
09:30:55 your report where I believe you discuss the results
09:30:57 of some of your validity tests, you mention a test
09:31:00 called the WMT. I'll give you a second to get to
09:31:05 that.
09:31:06 **A.** Is this the first or second report?
09:31:07 **Q.** The one of your testing in May, yes.
09:31:09 **A.** Yes. Okay.
09:31:10 **Q.** The first report, Exhibit 1. There is a
09:31:25 binder. It's Exhibit 1.
09:31:26 **A.** Government's Exhibit 1?
09:31:29 **Q.** Correct. Page 24 when you get there.
09:31:43 **A.** Page 24, did you say?
09:31:45 **Q.** Yes.
09:31:45 **A.** Thank you. Yes.
09:31:54 **Q.** So on that page you report that you used a
09:32:00 validity test called the WMT that Mr. Brockman
09:32:03 failed. Can you explain to the Court what the WMT
09:32:06 is?
09:32:07 **A.** Yes. WMT stands for Word Memory Test. Again,
09:32:15 it is a free-standing validity test that is designed
09:32:24 to look like a regular, verbal-memory type of test
09:32:32 that a person would not recognize as being a
09:32:34 validity test. It's rather sophisticated in that it

has scales within it that are very, very easy, and people with severe cognitive impairment can still do reasonably well on them.

It also has some scales that are a little bit harder than the easy ones. That way you can identify whether there's the proper differential between the easy part of the tests and the harder part of the tests. The harder part of the tests people don't do as well.

That should be the way with the clinical cases. People don't do as well on the harder part, as opposed to the easy part, and you can compare the scales to identify unusual patterns that don't make clinical sense.

Q. Did you observe this unusual pattern with Mr. Brockman in this test?

A. Yes.

Q. And in your data -- if we want to put that first graph up --

MR. COREY SMITH: And with your permission, Your Honor, Dr. Denney has included in his test data a graph of this test. I think the graph is down lower.

THE WITNESS: Right.

MR. COREY SMITH:

09:33:49 **Q.** Is that the graph?
09:33:50 **A.** It is.
09:33:50 **Q.** Could you explain what you depicted on this graph?
09:33:52
09:33:53 **A.** Sure.
09:33:55 MR. LOONAM: I'm sorry, where is this from?
09:33:57
09:33:58 MR. COREY SMITH: From his test data.
09:34:00 MR. LOONAM: Not from the supplemental report? This is from the --
09:34:02
09:34:02 MR. COREY SMITH: From the original report in June, yes.
09:34:03
09:34:04 MR. LOONAM: Is there an exhibit number to this or --
09:34:05
09:34:06 MR. COREY SMITH: We can mark it for identification. We're going to use its a demonstrative. We can mark it as Government's Exhibit 120. We're not going to use it for evidence.
09:34:08
09:34:10
09:34:15
09:34:17
09:34:17 MR. LOONAM: I know what it is, but...
09:34:22 MR. COREY SMITH:
09:34:22 **Q.** Dr. Denney, can you describe for the Court what you depicted in your graph with regard to this WMT validity test?
09:34:24
09:34:29
09:34:29 **A.** Yes. First of all, if I may answer one

09:34:31 question you asked just a moment before.
09:34:34 **Q.** Sure.
09:34:34 **A.** Atypical patterns -- this test -- there's two different initial ways you look at it. One is, is it a pass or fail? That looks at the easiest subtests. If the easiest subtests are below a specific cutoff, it's considered a fail. But then you have to do a further analysis to determine why it's failed.

09:34:56 Was it failed because a person has a genuine, severe cognitive impairment? If so, then that would be termed a genuine memory impaired profile. But then you have to look at that genuine impaired memory profile and determine whether there's atypical or implausible findings in it, compared to a person's day-to-day function.

09:35:22 That's what we'll do on this test.
09:35:24 **Q.** And in this administration of this test to Mr. Brockman, did he present memory impaired profile?
09:35:34 **A.** He did, by the mathematical algorithms in the test.
09:35:40 **Q.** But you also say in your report -- after you say he presented a memory impaired profile, you also say that he -- "A poor profile worse than the most

severely demented amnestic patients; what does that mean?

A. Yes, although he met the mathematical algorithm, which in this case is very easy, the mean easy score minus the mean difficult score -- or the other way around. It's the difference between the two, and if the difference is substantial enough that meets that simple algorithm.

He met that. However, you were also supposed to compare this profile to representative groups to see if it's plausible.

Q. Well, let's walk the Court through the chart here. You have these letters across the bottom, IR, DR -- can you explain for the Court what those are?

A. Yes, this test has different scales as I mentioned, harder ones and easier ones. That's what these represent. The IR is the immediate recognition. The way this test works is you present word pairs on a screen on the computer and you go through the list twice. The person is looking at it.

Then they have to immediately choose between one of the words on the list or a foil, which is a word that was not included in the list, and they have to select that. That's the IR,

09:37:10 the immediate recognition. This graph I should say
09:37:17 -- these scores are percent correct. So you see
09:37:21 that on the left is the percentage correct out of
09:37:23 the max 100 percent.
09:37:25 And then it's the blue line the
09:37:27 Defendant's scores. The next one is DR, delayed
09:37:34 recognition. So after the IR part is finished, the
09:37:37 first recognition part, you then have the examinee
09:37:48 doing something else, other cognitive tasks, but not
09:37:53 verbal related tasks. You don't intermix other
09:37:56 memory tests or anything like that in there.
09:37:58 They're non-verbal tasks, so to speak.
09:38:01 Then you come back to this task and
09:38:03 have him complete the delayed recognition. This is
09:38:07 the same type of task that is immediate recognition
09:38:12 where you -- the screen has one of the words that he
09:38:16 -- from the original list, but then a different
09:38:20 foil, which is a word that was never used before on
09:38:22 the test. They have to choose which word they
09:38:25 remember from the original list.
09:38:29 **Q.** Doctor, if I may interrupt, as you are walking
09:38:32 the Court through these tests, which line on the
09:38:34 graph represents Mr. Brockman's performance on the
09:38:38 test?
09:38:38 **A.** The dark blue line is Mr. Brockman's

performance.

Q. The gray, shaded area, what does that represent?

A. Thank you. The gray, shaded area is the impaired area based upon normative standards. It looked at people that have no memory problems, and then took two standard variations below the mean as the cutoff for what's impaired, what's not impaired. That's the difference between the light-colored background and the gray area. It's going beyond two standard variations below the mean.

Q. The dotted, colored lines above the solid blue line -- what do those represent?

A. Those are other comparative groups. Those -- in the program, you can choose comparative groups. You choose the groups most relevant for your particular examinee. So these comparative groups, you will notice they are all elderly with an exit score.

These people are -- are cognitively impaired individuals, and the exit score is a global assessment that can be used to scale how demented. So it's basically a measure for severity of dementia.

Q. You can continue. I interrupted you. The

09:40:11 description of the tests across the -- horizontal
09:40:14 cross the bottom?
09:40:15 **A.** Yes, CNS is consistency between the IR and the
09:40:19 DR -- the immediate recognition and are the delayed
09:40:23 recognition. If the examinee got the same word
09:40:27 right or got the same word wrong, this CNS keeps
09:40:31 track of that, and it's how consistent the person
09:40:36 was across those two prior measures.
09:40:40 **Q.** Mm-hmm.
09:40:41 **A.** The next one, MC, is multiple choice. I have
09:40:44 to backtrack a slight bit and say that the original
09:40:48 words presented on the screen for the examinee to
09:40:51 remember are actually word pairs. First word comes
09:40:56 on the screen, and then there's another word that
09:40:58 goes with it.
09:41:00 They're told that they're word
09:41:02 pairs, and to remember the word pairs. It would be
09:41:05 something like table/chair, for example -- that's
09:41:12 not actually from the test because I don't want to
09:41:14 start giving up the actual items -- but they are
09:41:16 semantically related -- mildly so. MC is multiple
09:41:28 choice. What the computer gives you is the first
09:41:30 word in the pair, and there's a list of five words
09:41:32 next to it, and you have to select the word that
09:41:35 went with this word.

So it's a multiple choice, paired measure. The next one, PA, is called paired associates. Now, I would turn the laptop away from the examinee, and I ask him to tell me the words that go with the word I tell him, so I tell him the first word in the word pair and ask him to give me the word that goes with it. So that's -- that's a cued, free recall; okay? It's a much harder task than the other tests.

Then the last one is FR, called free recall. That's where I simply ask the examinee to tell me all of the word pairs originally presented on the computer. He can give them to me in pairs, one at a time, or in any order and just do your best. Then I keep track of how many he gives me.

Q. And in that last test, how many did Mr. Brockman get right?

A. I believe zero. He -- he said he was not able to recall any of them.

Q. So in this validity test you administered in May of this year, how did Mr. Brockman do against these other control groups that are listed on the graph?

A. He performed -- well, let me explain. The exit

score, zero to nine, would be mild, cognitive impairment problems. Ten to fourteen is more serious. Fifteen to nineteen more serious. Twenty to twenty-four would be moderate to severe. Twenty-four-plus is severe.

These are severely impaired, inpatient, demented people. They were literally inpatient when they were examined. And so he performed worse than the most severely demented people on all scales except his consistency, which is the last thing you would expect to be as good as them, because that tells you he was actually pretty consistent. He was more consistent between immediate and delayed recall than his other scores, but still nonetheless he was as consistent as the most severely demented individual.

Q. So is this a test that Mr. Brockman failed -- a validity test that he failed?

A. He failed, but it produced what's called a genuine memory impaired profile. But when you look at the comparative groups, in my professional opinion it does not correspond with reality because it is so extremely impaired.

Additionally, the fact that his multiple-choice score and paired associate scores

09:44:22 are the same raises a red flag for me as well. That
09:44:25 appears rather implausible, because as you can see
09:44:28 from all of the other scores on there, the more
09:44:31 impaired a person gets the worse they do on paired
09:44:35 associate, compared to multiple choice. Because
09:44:39 paired associate is a more difficult task than
09:44:41 multiple choice.
09:44:41 **Q.** Now, the line -- the through -- solid blue line
09:44:45 Mr. Brockman's chart -- his scores on these subtests
09:44:48 is different in shape than the control group dotted
09:44:53 line scores. How does that inform you on your
09:44:55 analysis of Mr. Brockman's cognitive abilities?
09:44:58 **A.** Yes, the difference between his easy scores,
09:45:04 which would be IR, DR and CS, and the more difficult
09:45:08 scores of MC, PA, and FR is extreme. You'll notice
09:45:12 that the difference between the easy and hard scores
09:45:15 is much more extreme in his case than they are in
09:45:18 any of the other dementia cases.
09:45:20 That suggested to me that it's an
09:45:26 atypical profile that makes me believe it's not a
09:45:29 valid reflection of his genuine abilities.
09:45:31 **Q.** Now, in your June report, which is the May 2021
09:45:37 testing, on that same Page 24 you mention a test
09:45:41 called the NV-MSVT. What is that?
09:45:45 **A.** This NV-MSVT is a short for Non-Verbal Medical

09:45:55 Symptom Validity Test.
09:45:56 **Q.** What kind of test is that?
09:45:58 **A.** That is a free-standing validity test as well.
09:46:01 **Q.** How did Mr. Brockman do on that test?
09:46:04 **A.** He performed poorly -- let me refresh my
09:46:18 memory.
09:46:18 **Q.** It's on Page 24.
09:46:19 **Q.** Thank you. He performed poorly, so it was a
09:46:22 fail. But based upon the mathematical algorithm, it
09:46:27 suggested it could be a possibly genuine memory
09:46:29 impaired profile. However, again you have to look
09:46:33 at the profile and see is it -- is it a plausible
09:46:36 genuine memory impaired profile compared to relevant
09:46:41 criterion groups?
09:46:42 **Q.** Did you prepare a similar graph with regard to
09:46:45 that test as we just saw for the WMT test?
09:46:49 **A.** Yes, I did.
09:46:50 **Q.** Can you put that up?
09:47:01 Can you describe again for the Court
09:47:03 what your graph depicts for the Court on the NV-MSVT
09:47:09 test?
09:47:09 **A.** Yes, this test is by the same publisher, so
09:47:13 it's laid out the same way here. Because although
09:47:16 this is my figure here today, it's actually from the
09:47:20 actual test itself. So this test is a little bit

09:47:26 different, because it's not a verbal memory task.
09:47:30 You are not giving word pairs on the screen.
09:47:32 Rather, it is giving picture pairs.
09:47:35 So there is a picture of an object -- like typically
09:47:42 an animal or something like that. Then there's
09:47:46 another object with it, so it's a pair of objects in
09:47:50 that picture. And instead of 40-such objects or
09:47:58 words like the WMT, it's only 20. So it's much
09:48:02 simpler in that regard. It's easier.
09:48:08 Then the other scales get into the
09:48:10 characteristics of the test. IR is immediate
09:48:14 recognition, similar to the word memory test. It's
09:48:17 immediate. After the presentation on a screen, you
09:48:20 go through this -- go through the pictures twice,
09:48:23 and then you test his recognition for it. You have
09:48:27 to choose between this picture or that picture. One
09:48:30 was right and one was not shown.
09:48:33 And then, after a ten-minute delay
09:48:36 -- so not a 30-minute delay, just a ten-minute delay
09:48:39 -- you come back and do it again with the original
09:48:43 pictures, but different foils. You have to choose
09:48:46 them and recognize them. It's very easy. Then the
09:48:50 CNS is the consistency between the two.
09:48:52 Then the next two scales are also
09:48:55 very -- they're recognition tests, but they're

unique in that the nature of the foils are different. The delayed recognition archetypes mean that the foils, the wrong answers, are emotional pictures -- something that would elicit a bit of an emotional response. That's why it's called archetypes like snakes, eyes looking at you or a dagger -- something you would recognize right away. "Well, I didn't see that picture before."

Then the DRV stands for delayed recognition variations. On this one, it has the original picture with the two items -- for example, a dog and a bone -- and then it gives you a different picture with a variation, say a dog with a frisbee in its mouth, right, instead of a bone. So it's a harder subtest, because the foils are much more like the original pictures.

Then paired associate with the computer shows the first -- one of the pictures with one of the objects, and then I asked the examinee, "What went with that picture? It's a picture of a dog, so what went with it?" He tells me and I type it in.

Then the free recall is at the very end. I say, "Now I would like for you to give me all of those original ten picture pairs," you know.

"You can give them to me one at a time or in pairs, just as many as you can in any order."

Then I put in the computer his performance for free recall.

MR. COREY SMITH: I apologize, Your Honor. I forgot to put on the record. We're marking this for identification as 121. Government's Exhibit 121.

Q. So which line on your graph is Mr. Brockman's score on this NV-MSVT test?

A. Like the first one, it's the dark blue line.

Q. How did Mr. Brockman do on this test when compared to the other control groups that the dotted lines?

A. It's a fail, first of all. However, I think I mentioned the mathematical rules are such that it would be considered a possible or -- possible genuine memory impaired profile, but then you have to look at the overall pattern compared to appropriate comparison groups to make that final determination.

And in this case, these other groups I put up here to compare to are -- well the green line are 48 sophisticated simulators, people

that are simulating dementia but they're graduate students in psychology.

Then the next group are 33 Missouri Memory Center clinical dementia cases. These are people from my own caseload who -- as a matter of fact, they are in the last couple of years people diagnosed with dementia. I placed them in there. The next group -- I think it's lavender/purple color are 49 dementia patients. The next group are a mixed dementia group who pass the original criteria for the NV-MSVT. And the next is a mixed dementia group who failed the easy item on the NV-MSVT.

So they're all dementia patients except the simulators.

Q. How did Mr. Brockman do as opposed to those other control groups?

A. Well, his scores fall -- the first set of scores fall within a reasonable range of the other groups, although the pattern is not the same because he is in the impaired range on the easiest aspect of the test. But then on the DRV he gets 100 percent correct. That's quite atypical.

Q. In your report from June of this year on Page 24, you are describing this test. I want to ask you about something that you said in the report.

09:53:30 In the second full paragraph, the last sentence
09:53:33 where it starts, "The disparity"; do you see that?
09:53:37 **A.** Page again?
09:53:40 **Q.** Page 24.
09:53:41 **A.** "The disparity," yes.
09:53:44 **Q.** So you are saying, "The disparity indicated the
09:53:48 profile was not created by a person with dementia,"
09:53:51 and then you go on. What do you mean by that and
09:53:53 how do you draw that conclusion?
09:53:55 **A.** Well, what you see is he did -- he placed the
09:53:59 easy -- easy scales up very, very high. Although
09:54:04 DRV is 100 percent, that's atypical. That should --
09:54:08 if you look at the compared to other dementia cases,
09:54:11 particularly as they become more demented, DRV
09:54:15 drops.
09:54:15 Because there's always the same
09:54:16 curve is what you would expect. It's a nice,
09:54:19 gradual curve -- mild cognitive impairment causes a
09:54:22 mild curve. Actually, normal performance is a mild
09:54:27 curve -- well, not so much. Once you get into the
09:54:33 cognitive impaired range, that curve continues to be
09:54:36 mild, gradual decline, but it drops lower on the
09:54:39 scale. Everything drops. That's what you see. You
09:54:43 can see that pattern over, over, and over again with
09:54:45 the dementia patient groups.

His doesn't do that same pattern. He does below criteria for the easiest items, then does 100 percent on DRV, and then for paired associate and free recall we see a drastic drop where he's performing down at the 20 percent correct and zero percent correct.

When you compare that to the actual genuine dementia patients, their pattern is not like that. It's -- it's very odd to see a pattern like this in my experience. I use this test on all of my dementia exams in the clinic.

Q. So the fact that you observed atypical scoring patterns of Mr. Brockman in these two validity tests we just walked the Court through, what does that tell you, in your professional opinion, about Mr. Brockman's cognitive scores in these cognitive tests that he took?

A. I don't believe his cognitive scores reflect genuine, severe cognitive impairment.

Q. Why is that?

A. I don't believe the patterns are consistent with what you see with genuine demented patients.

Q. Now, another -- let me move to another test. That same page in your report from June of 2021, you mention, in the third paragraph, a test called the

09:56:08 VSVT. What is that test?
09:56:11 **A.** The VSVT stands for Victoria Symptom Validity
09:56:17 Test. This is also a computer-generated -- or
09:56:22 computer-administered test. Rather than words or
09:56:26 pictures, it uses numbers however. It shows a
09:56:30 five-digit number on the screen, and then the number
09:56:34 goes away.
09:56:35 And then after a few seconds two
09:56:38 five-digit numbers show up on the screen, and the
09:56:42 person has to click the key on the left side or the
09:56:44 right side on the computer to choose the number on
09:56:49 the left or the number on the right, which was, in
09:56:52 their view, the same as the number they just saw.
09:56:54 So it's a recognition task.
09:56:56 You see the first five-digit
09:56:59 number. Then it goes away. Five seconds later two,
09:57:03 five-digit numbers and you select the one you saw
09:57:05 from just before.
09:57:06 **Q.** How did Mr. Brockman do on this test?
09:57:09 **A.** He performed poorly on it. If I can explain?
09:57:20 There are what are called easy items and hard items.
09:57:27 Even though they're labeled easy and hard, they're
09:57:29 both pretty equally easy, okay?
09:57:34 But the ones that are labeled hard
09:57:37 -- instead of being a completely different

five-digit number as the foil, it's the same five-digit number but with the middle numbers transposed, okay? However, you can look at it and see the first numbers are not the same immediately. And so it's still strikingly easy task, but that's why they call it hard because it's similar numbers.

And on that part of the task -- I mean Mr. Brockman performed poorly on this across the board, but on those hard items -- and the reason it's done that way is because it's -- it's a bit of a bait for the person. They think this is harder, then they'll perform more poorly on the hard items, which is exactly what Mr. Brockman did. He did more poorly on the hard items than the easy items, which number one does not make a lot of sense.

Second, he performed so poorly on the hard items that he was below the cutoff we use, even in dementia cases, to suggest a positive finding based upon research. But his score was also low enough that from a probabilistic perspective, he should have done better if he was blindfolded.

Q. What was his score on this test back in May of 2021?

A. On the hard items?

Q. In the overall test, the Victoria Symptom

09:59:08 Validity Test, what was his score? It's in your
09:59:11 report, I think -- Page 24, the third paragraph.
09:59:26 **A.** Okay. Yeah. It's -- yeah, I only put in here
09:59:29 the score on the hard items.
09:59:32 **Q.** Okay.
09:59:32 **A.** I don't recall, off the top of my head, what
09:59:35 his score was on the easy items, but they were below
09:59:39 the typical criterion for suggesting putting forth
09:59:43 good effort. But his hard items were much lower,
09:59:48 and so I focused on that. He only obtained 8
09:59:50 correct out of 24 items on that hard-item scale.
10:00:01 **Q.** That 8 out of 24 on the hard-item scale, is
10:00:04 that a pass or a fail?
10:00:05 **A.** Oh, it's a fail. Anything below 11 in a
10:00:08 dementia context would be considered a fail.
10:00:10 **Q.** Now, we haven't gotten to it yet -- and we'll
10:00:16 get into it a little bit more later -- the
10:00:18 psychologist retained by Mr. Brockman in this case
10:00:22 also performed some cognitive testing,
10:00:26 Dr. Guilmette. Are you familiar with the reports
10:00:27 he's produced?
10:00:27 **A.** Yes.
10:00:28 **Q.** Have he reviewed them?
10:00:29 **A.** Yes, I have.
10:00:30 **Q.** Does Dr. Guilmette address your scoring of

Mr. Brockman in the Victoria symptom validity test?

A. Yes, he does.

Q. Is his opinion the same as yours?

A. No.

Q. What's his opinion?

A. Well, he said that that score of eight falls in the random range. He's -- I have to back up. I'm sorry. Let me explain how the test works in order to make this answer understandable. It's a two-alternative, forced-choice task. There's two options, and the person has to choose between one of the two options.

So if -- so it's analogous to flipping a coin. If you flip -- let's assign heads as one and tails as zero. If we flip a coin multiple times and we average the result, it's going to be approximately 50 percent. It's not going to be exactly 50 percent, but it will make a bell-shaped curve. We can use that bell-shaped curve -- curve based upon what's called the binomial theorem, which tells a person with no ability should perform within the random range.

The further they get away from the mean, you can calculate the odds of that happening by random chance alone. So imagine him taking the

test blindfolded, okay? He obtained a score of eight. Well, in classic test theory where we're performing psychological testing between means of groups of subjects with maybe Diet Coke® versus, you know, a person's preference for Diet Pepsi™ -- whatever -- we typically use, in science, a probability of p-value, 0.05, which tells you that it goes so far out into the -- out into the tails of the curve that it would only occur, you know, less than five times out of a hundred.

It's a very rare event, and we use that then to say, "Okay, well then this is not -- not due to random events. This is due to the experimental effect, whatever that is."

In this case, that would -- a .05 level would correspond to a seven wrong on the hard items. Mr. Brockman obtained eight -- I'm sorry, not seven wrong, seven correct on the hard items. Mr. Brockman obtained eight correct on the hard items.

So it's above the p-value .05, but it is right next to it. And subsequent research regarding that p-value, which is -- for him it was specifically 0.0758 or less than p-0.8, okay? So using the binomial theorem, less than 8 people out

of 100 would perform that way if they were blindfolded.

The subsequent research that came out in 2014 and 2019, I believe Binder and Millis -- or Binder, Larrabee and Millis, and Binder and Chafetz research says that in the forensic setting of a real evaluation of somebody in a forensic setting where there's potential for secondary gain, scores falling below a probability of p-value .2, okay, which would be much higher than eight, is still so low as to tell you the person intentionally chose the wrong answer.

He must have known the right answer, but then intentionally chose the wrong answer more often than it would occur in clinical patients.

Q. Did you cite this literature you are now describing for the Court in your report from June of 2021?

A. I did.

MR. COREY SMITH: May I approach the witness, Your Honor?

THE COURT: You may.

MR. COREY SMITH: I'm going to hand the witness copies of the articles he footnotes in his

report, and I'd like to mark them for identification as 121 -- 121, 122.

THE COURT: Okay.

MR. COREY SMITH: 122 and 123, Your Honor -- just for the record, 122 is the article by Laurence Binder and Michael Chafetz entitled, "Determination of the Smoking Gun of Intent, Significance of Testing of Forced-Choice Results in Social Security Claimants."

And 123 is, "Intent to Fail Significance Testing of Forced-Choice Results" by Laurence Binder, Glenn Larrabee and Scott Millis. We're going to offer those into evidence as part of Dr. Denney's testimony.

THE COURT: Any objection?

MR. LOONAM: Whether it's entered into evidence or cited and quoted to the Court doesn't really matter. No objection.

MR. COREY SMITH:

Q. My question with regard to the two articles you cite in your report, what does it mean to you that in this test, Mr. Brockman scored 8 out of 24 on the hard items in this validity test? How does that inform your professional opinion?

A. That tells me that Mr. Brockman knew the right

10:06:17 answers, but intentionally chose the wrong answers.
10:06:22 That, as they say -- you hate to use the term
10:06:25 smoking gun, but that's what they're saying. It's
10:06:27 indicative of intent to perform poorly.
10:06:31 **Q.** Now, I want to ask you a few more tests you did
10:06:34 in May, and then move on to your October testing.
10:06:38 I'll point you to where in your report, just to help
10:06:41 refresh your memory, Page 26. You talk about a test
10:06:45 called the NAB® Memory Verbal Learning -- I think I
10:06:48 got that right from your report?
10:06:54 **A.** As a validity test?
10:06:55 **Q.** No, no, no. You cite this test?
10:06:57 **A.** Yeah, it's the NAB®, Neuropsychological
10:07:00 Assessment Battery Memory Module. It's the primary
10:07:04 memory index of that memory battery.
10:07:07 **Q.** Can you explain for the Court, briefly, what
10:07:09 this test is? If this is not a validity test as you
10:07:12 said, it's a cognitive test?
10:07:14 **A.** Yes, standard neuropsychological test on
10:07:17 memory.
10:07:18 **Q.** So what -- well, if you can describe the test
10:07:21 briefly, and then what did you discern from the
10:07:23 results you obtained from Mr. Brockman about his
10:07:26 performance on the test?
10:07:27 **A.** Yes, this is a battery of learning and memory

10:07:30 test that combine together. And over the course of
10:07:34 about 40 minutes, give you scores in the area of
10:07:38 verbal learning ability, non-verbal learning, and
10:07:43 then verbal recall, non-verbal recall, and then also
10:07:49 a combination of audio and visual recall.
10:07:54 Gives you a total score, as well as
10:07:56 subscores related to a person's memory.
10:08:02 **Q.** So those scores -- what does that tell you
10:08:06 about Mr. Brockman and the overall assessment of his
10:08:10 cognitive ability, and I should say answer that
10:08:13 first before I ask another question?
10:08:15 **A.** Well, putting validity issues aside, he scored
10:08:19 with an overall index score of 58, which is grossly,
10:08:26 grossly impaired. It's a standard score with a mean
10:08:29 of 100 standard deviation of 15. So it's similar to
10:08:33 an IQ score -- same scale.
10:08:37 A 58 would be almost three standard
10:08:42 deviations below the mean. It's severely, severely
10:08:46 impaired.
10:08:46 **Q.** So if you take this test score, this NAB®
10:08:49 memory test score in isolation away from the
10:08:51 validity tests and other -- other data, it presents
10:08:55 as if Mr. Brockman is severely impaired in the
10:08:57 memory area?
10:08:59 **A.** Yes. If this were a genuine result that

10:09:01 reflects a person's real ability -- yeah, a grossly
10:09:07 impaired memory.
10:09:08 **Q.** You comment on these -- these memory tests on
10:09:10 Page 27 of your report, the third paragraph. I'd
10:09:13 like to point you to that paragraph, if I may.
10:09:17 THE COURT: Which page?
10:09:20 MR. COREY SMITH: 27, Your Honor, of
10:09:22 the June report.
10:09:24 THE WITNESS: Yes, I see it.
10:09:26 MR. COREY SMITH:
10:09:26 **Q.** The third paragraph down starts with,
10:09:29 "Overall." You say, "Brockman's scores during the
10:09:33 memory learning do not make clinical sense."
10:09:36 What do you mean by that?
10:09:38 **A.** Two things. They -- number one, they were
10:09:42 extremely -- they were severe, and that severity was
10:09:47 not consistent with the man I was seeing and talking
10:09:52 to, and who demonstrated recollection for what
10:09:56 happened the day before in my examination versus the
10:09:59 day after.
10:10:01 He specifically remembered the
10:10:03 details of the instructions related to the MMPI we
10:10:07 tried to start the day before, and he spontaneously
10:10:09 brought that issue up the next morning. These
10:10:12 results are so severe that if they were genuinely

reflecting -- or if they were reflecting genuine impairment, he would absolutely not have been able to have done that.

The second aspect of them that make them look not right is that he did not show the pattern where people would learn -- they tend to learn better, but then they are more poorly -- or they're more impaired on their free recall of that information afterwards, which is a classic type of problem you see with dementia.

They can learn -- maybe they learn slowly, but what they learn they can learn. And then they do more poorly on the free recall. He didn't do that. He was pretty flat across the board, except for his non-verbal learning and retention were up in, I believe, the reasonably normal ranges.

That's pretty striking. For somebody to be that globally impaired, and yet normal ranges on the nonverbal portions of the test again does not make clinical sense. I do not see that in the clinic, and I use this memory battery on every person I evaluate at the memory clinic.

Q. So overall, in your May testing of Mr. Brockman, what conclusions can you draw from

10:11:32 both the cognitive testing, the validity testing,
10:11:37 and the overall pattern of his test scores? What --
10:11:41 in your professional opinion, what conclusion can
10:11:42 you draw?
10:11:44 **A.** That he was intentionally exaggerating his
10:11:47 cognitive impairment on the testing.
10:11:51 **Q.** Now, let's turn to the more recent testing in
10:11:54 October of this year, just of last month. Did you
10:11:56 obtain similar results in October that you did in
10:12:00 May? That's Exhibit 2 if you want to look at your
10:12:04 report. It's government's Exhibit 2, pre-admitted.
10:12:08 **A.** Yes. In rough summary, yes, I found similar
10:12:15 results.
10:12:17 **Q.** So if I can ask you to turn to Page 11 of your
10:12:21 October report. If we can put this page up? Yep.
10:12:36 I believe that page is on the screen for you.
10:12:38 **A.** Yes.
10:12:40 **Q.** This screen is entitled the -- make that
10:12:45 larger?
10:12:51 Dr. Denney, which chart would be --
10:12:55 **A.** Well, we can -- we'll look at both of them. We
10:12:58 can look at the top one. That's fine.
10:13:00 **Q.** The first thing I want to ask you, is this the
10:13:03 same test you administered to the Defendant,
10:13:07 Mr. Brockman, back in May of this year?

10:13:09 **A.** Yes, it is.
10:13:10 **Q.** How does this compare -- this is the October
10:13:12 result; is that right?
10:13:14 **A.** Yes.
10:13:14 **Q.** How does that compare to the chart we saw
10:13:17 earlier this morning from the May test?
10:13:20 **A.** Well, it is also a fail with the basic
10:13:24 algorithms, because on the easiest subtests -- the
10:13:41 IR, DR, CNS -- he fell below criteria, so it's a
10:13:44 fail.
10:13:46 The algorithm for the test would
10:13:51 suggest it could be a possible, genuine memory
10:13:56 impaired profile if it is compared to relevant
10:14:04 criterion groups, and is deemed to be a plausible
10:14:08 profile.
10:14:09 **Q.** Just to be clear, this is the same validity
10:14:12 test that you administered in May; is that correct?
10:14:15 **A.** Yes, it is. So he performed more poorly on the
10:14:18 easy items than he did in May, but he -- and he
10:14:22 performed very poorly also on the more difficult
10:14:24 items, although he got five percent correct on the
10:14:27 free recall this time. Last time he got none
10:14:30 correct.
10:14:30 **Q.** And how does he compare against these control
10:14:33 groups that you have in the dotted color lines?

10:14:37 **A.** The control groups, as you can see listed on
10:14:40 the bottom there, are mixed dementia group, another
10:14:45 mixed dementia group, neurology patients who have
10:14:50 dementia, and then 33 Missouri Memory Center
10:14:55 clinical dementia cases.
10:14:56 Then that bottom one, 48
10:14:59 sophisticated simulators out of a research study, I
10:15:06 pulled that data out.
10:15:07 **Q.** So how does that inform your professional
10:15:09 opinion -- let me rephrase that question and make it
10:15:12 clearer. Mr. Brockman's score, the solid blue line
10:15:16 -- when compared to the control group -- how is his
10:15:19 profile of his scores informing your professional
10:15:23 opinion about whether or not Mr. Brockman is truly
10:15:25 taking these tests or exaggerating -- faking his
10:15:29 symptoms?
10:15:29 **A.** Right. You can see the overall, arching
10:15:33 pattern of his scores, the curve of his scores do
10:15:36 not match the curve of the dementia patients.
10:15:39 Dementia patients have a same type of pattern,
10:15:44 basically. Except if it's more severe, the pattern
10:15:48 is lower on the scale.
10:15:50 But it has that same curve down to
10:15:52 the right. Mr. Brockman's performance, he performed
10:15:58 worse than them on the easiest portions of the test

and actually performed in the range -- the malingerer, the simulators do. Yet, he performed better on DRA and DRV than he did on the easier IR score.

Then we see a drastic drop to paired associate and free recall, a straight line down rather than a curve like you see with the other dementia patients. That tells me that his profile is not consistent with genuine dementia.

Q. So you scored this as a failed validity test in October?

A. Yes. I would rate this as a fail, based upon the implausible of his profile, compared to appropriate criterion groups.

Q. Does that mean he was intentionally trying to fail the test?

A. I can't say from this test whether that indicates he was intentionally. I'm just saying his profile in this test is not consistent with genuine dementia.

Q. Another test you performed in October -- Page 12 of your October report -- it's Green's MSVT. It's up on the screen. Is that a test you also administered in May of 2021?

A. Yes, it is.

10:17:26 **Q.** And how did he do on this test? How did
10:17:29 Mr. Brockman do on this test -- well, first, how did
10:17:32 he do on this test in October of 2021?
10:17:36 **A.** Very poorly. You want me to explain this test?
10:17:38 Because we haven't explained it yet.
10:17:40 **Q.** Yes, let's go ahead and explain this test for
10:17:42 the Court. What it is?
10:17:43 **A.** Thank you. The MSVT stands for Medical Symptom
10:17:48 Validity Test. This is the sister test to the
10:17:50 non-verbal MSVT.
10:17:53 It's -- it's a word test as well,
10:17:56 so it uses words but they're very simple words.
10:18:00 It's arranged in a way similar to the -- that other
10:18:03 word memory test that we talked about, except
10:18:08 instead of 40 words, it's only 20 words and they're
10:18:10 at a first-grade reading level.
10:18:13 They are strong word pairs that are
10:18:16 connected together -- words that are actually
10:18:21 compound words using an example just like an item
10:18:26 from the test, but not from the test, would be like
10:18:29 shoe/laces for example. The person views these word
10:18:33 pairs on the screen of the computer.
10:18:38 Again, there's ten-word pairs for
10:18:41 20 words total. You look through the list twice to
10:18:44 learn them, and then it measures the person's

immediate recognition just like before, you choose which word you remember from the list compared to a foil they've not seen, and then you do that for the immediate recognition.

Then, after a ten-minute delay you come back and do it again, but with new foils so you are not confusing them with foils. They have to choose the word they remember from the original list, and then the CNS again stands for consistency. PA stands for paired associate.

In this instance, I turned the computer away from the examinee and I say, "Okay. I'm going to say the first word in the word pair, and you tell me the word that went with it. So for example, what word went with shoe" -- in my example earlier where I used the word shoelace, and he would give me the second word that goes with it.

It's a compound word, so the two words are strongly associated, and that's what paired associate score is, percent correct. Then the free recall is, as you would expect, "I would like you to tell me all of the word pairs you remember from the original list. You can give them to me in pairs, or one at a time -- any order, just do your best."

10:19:56 **Q.** How did -- how did Mr. Brockman do in this
10:19:59 test?
10:20:00 **A.** He performed very poorly.
10:20:02 **Q.** And is it similar to his performance back in
10:20:04 May?
10:20:09 **A.** I did not administer this test in May.
10:20:11 **Q.** Okay. I'm sorry.
10:20:12 **A.** So I don't have a comparison on that.
10:20:16 **Q.** So let me just focus on this test in October.
10:20:18 So when you administered this test in October and he
10:20:21 did poorly, would you mark that as a fail or as a
10:20:24 pass?
10:20:25 **A.** Well, I'll walk through the algorithm with you
10:20:27 briefly. It's a fail for the first criterion,
10:20:31 because the IR, DR and CNS are well below where they
10:20:34 should be.
10:20:35 The second half of that to
10:20:37 determine whether it's a genuine -- potential
10:20:40 genuine memory impaired profile then is the
10:20:42 difference between the easy and hard subtest scores.
10:20:47 On this particular task, because his free recall was
10:20:50 so low compared to his immediate recognition score,
10:20:54 it met the easy/hard difference for a possible,
10:20:58 genuine memory impaired profile. But, you have to
10:21:03 compare that to relevant criterion groups to see is

it a plausible profile.

And in this instance it's not, because the IR, DR and CNS are way too low. There's research regarding this that came out in 2021 by Cerny and colleagues, that showed when you average the easy scores -- take the mean of those three -- if it's below 75 it's a fail, even in mixed clinical groups that include dementia patients.

Q. Now -- so this is two validity tests that Mr. Brockman, in your opinion, failed October of this year, last month?

A. Yes, in my opinion this would be classified as a fail because it's not plausible compared to those severe dementia patients as you see.

Q. Let me ask you about another validity test that you administered in October of this year, the Rey-15-Item Test. Can you explain what that test is for the Court? First of all, did you administer it to Mr. Brockman?

A. Yes, I did.

Q. Can you explain to the Court what is that test?

A. This is a test that was developed in the 1930's and 40's. I believe published in -- yeah, 1940's. Might have been the early 50's. It's an exceedingly simple task.

10:22:30 **Q.** I think we have your test sheet from your data
10:22:33 to help you explain to the Court what the test is.
10:22:35 **A.** Yeah, not that one yet. Okay -- the way this
10:22:44 works is I would show this piece -- let me set the
10:22:46 stage.
10:22:47 "Okay. Sir, I have a page here
10:22:54 with 15 different things on it. I'm going to let
10:22:56 you look at it for just a few seconds, and then I'm
10:22:59 going to take it away and I would like for you to
10:23:01 draw as many of those 15 different things as you
10:23:04 possibly can," then you would normally show it to
10:23:09 the person for ten seconds.
10:23:10 But with elderly people research
10:23:12 says they need a little more time, so you show it
10:23:16 for maybe 20 or 30 seconds. I showed it to him for
10:23:19 30 seconds. Then you take it away, and you have the
10:23:22 person draw as many of those 15 things they can on a
10:23:25 piece of paper immediately afterwards. Sometimes
10:23:28 you wait ten seconds, depends on the research. I
10:23:32 just did it pretty quick right away.
10:23:35 And as you can see, the pattern is
10:23:39 obvious. Once you get a quick glimpse of this, you
10:23:44 understand the pattern. That's what makes it
10:23:47 actually a great validity test in this regard,
10:23:49 because it seems like it's going to be hard, but it

10:23:53 is actually very easy.

10:23:57 Now, you want me to say how

10:23:59 Mr. Brockman performed on --

10:24:02 **Q.** Yeah, how did Mr. Brockman do on this test? I

10:24:04 think we have this test sheet from your test.

10:24:06 **A.** Yeah, he only -- he only recalled one of those

10:24:09 items. That's pretty poor. Most people, even with

10:24:17 cognitive impairment, can remember nine of those.

10:24:20 **Q.** On the screen -- sorry to interrupt,

10:24:22 Dr. Denney. You have it up in the corner?

10:24:25 **A.** Yes.

10:24:25 **Q.** Is this Mr. Brockman's --

10:24:27 **A.** That is, yeah, Mr. Brockman's Rey-15 and free

10:24:31 recall test. He started to draw a clock, and then

10:24:34 stopped doing that and he drew another -- looks

10:24:37 somewhat like a circle -- might have been start of

10:24:42 another clock. He stopped, and then he drew the

10:24:44 third one down, a circle on the bottom.

10:24:46 So I count this as a one, because

10:24:48 that circle on the bottom would be consistent with

10:24:50 the circle you saw on the stimulus page. And these

10:24:54 other two marks are called intrusions.

10:24:57 **Q.** What is that?

10:24:59 **A.** Things that should not be there. They were not

10:25:02 a part of the original stimuli. And in elderly and

10:25:08 cognitively impaired people when you get intrusions
10:25:11 they're exceedingly rare, so much so that they could
10:25:14 be considered a positive finding on this validity
10:25:18 test when a person does that. But then there is a
10:25:21 recognition task to this test, too, that should
10:25:25 always be administered with it.
10:25:27 **Q.** Did you administer the second portion?
10:25:29 **A.** Yes, I did. And that recognition test was
10:25:33 developed by Kyle Boone in, I think, 2000. So it's
10:25:39 a much more recent addition to this task.
10:25:41 **Q.** I think we have that sheet for you to describe
10:25:44 to the Court.
10:25:49 **A.** For this -- after they have drawn what they can
10:25:51 remember of the original 15 items, I pulled out this
10:25:55 sheet and say, "Now I have a sheet with 30 different
10:25:59 items on it. I would like for you to circle the
10:26:04 items you remember from that original page I showed
10:26:06 you," and then they draw.
10:26:08 Again, it's immediately after
10:26:10 they're done drawing the first page, and then they
10:26:12 circle the answers here. For most individuals, you
10:26:19 take a combination of the free recall score and the
10:26:22 recognition scores. If it's below 22, it's positive
10:26:28 for indicating not valid.
10:26:32 For people who are older, you

10:26:34 cannot use that rule. You have to change them for
10:26:36 people who are older and probably have some
10:26:39 cognitive problems, such as dementia.
10:26:41 Then there is a new algorithm that
10:26:46 came out in 2017, where you take the -- you look at
10:26:51 this recognition task and you take the true
10:26:53 positives, that is the correct answers they circle
10:26:57 minus the false positives -- those are the wrong
10:27:00 answers they circle -- and then you -- I'm sorry,
10:27:05 you take the true positive and you minus the false
10:27:08 positives, and then you subtract the intrusion from
10:27:10 the first page. Anything less than two is a
10:27:13 positive indicator for invalidity among elderly
10:27:18 people with cognitive problems.
10:27:20 Additionally, that paper said you
10:27:23 need to let the person look at the Rey longer. You
10:27:26 give them some accommodation.
10:27:27 **Q.** On this Rey-15 Test, how does Mr. Brockman's
10:27:32 performance on this test inform your professional
10:27:34 opinion of his cognitive testing?
10:27:41 **A.** His summary score using the Fazio, Faris and
10:27:46 Yamout paper, which was cited in my -- my report, as
10:27:48 well as Dr. Guilmette's -- using that algorithm,
10:27:51 this is a fail because he obtained a score of one,
10:27:54 which is below two.

10:27:55 **Q.** So far in October, we have three failed
10:27:59 validity tests that we've walked you through?
10:28:01 **A.** Yes, in my opinion they were all failed.
10:28:03 **Q.** Did you compare some of this test results --
10:28:07 it's actually Page 15 of your supplemental report,
10:28:09 if I can ask you to look at that.
10:28:16 **A.** Oh, sure.
10:28:17 **Q.** Okay. So is this a summary of your analysis of
10:28:21 Mr. Brockman's testing?
10:28:23 **A.** Well, kind of.
10:28:25 **Q.** Okay. Why don't you describe for the Court
10:28:27 what it is.
10:28:28 **A.** Let me switch gears for you real quick. We're
10:28:30 not talking about validity tests anymore. This is
10:28:33 not a validity test. This is the profile, printout
10:28:39 of the NAB® -- which is again the Neuropsychological
10:28:42 Assessment Battery Memory Module. That's that
10:28:47 40-minute task I described earlier.
10:28:50 I administered that task with
10:28:52 Mr. Brockman in May of 2021, and I administered the
10:28:56 same task -- 40-minute task in October of 2021.
10:29:01 This is a graph of his performance on each of the
10:29:06 subscales of those NAB® batteries, both of them
10:29:11 superimposed on top of each other.
10:29:13 **Q.** This analysis -- how does this inform you about

10:29:17 Mr. Brockman's tested memory and cognitive ability?
10:29:23 **A.** Well, it reflects what I said before, severe
10:29:26 performance across the board. And the overall
10:29:30 summary index, by the way, was 58 back in May and
10:29:36 was again 58 in October. So exactly the same,
10:29:41 severe overall performance on this memory battery.
10:29:44 When you look at the subscale
10:29:46 scores, you can see they're virtually the same
10:29:49 across the board. What you also notice is, as I
10:29:52 said earlier, he did not do better in his learning
10:29:55 scores than he did in his recall scores. They were
10:29:59 all pretty across the board impaired.
10:30:04 As a matter of fact, in short term
10:30:08 -- or in the story learning, he actually did better
10:30:12 during the delay than he did on the learning part,
10:30:14 which doesn't make clinical sense.
10:30:16 **Q.** Well, why is that, that doesn't make clinical
10:30:20 sense?
10:30:20 **A.** The way memory works for pretty much everyone
10:30:24 until they are morbidly impaired -- you know, maybe
10:30:30 morbidly is not a good word to use -- grossly
10:30:34 impaired to such a degree that you probably wouldn't
10:30:36 even need to test them, it's obvious by looking and
10:30:40 talking with the person they're so terribly impaired
10:30:44 I'm probably not going to get useful result out of

it. It's almost untestable. At that point, it'll be kind of flat.

But prior to that, even with dementia you are going to see a pattern that the person does better on their learning tasks than their free recall tasks or delayed memory tasks, because that's the way it works. You work with somebody through multiple trials like word-list learning. I read the list to you once, twice, three times -- some tests do it five times -- and you show a learning curve.

Even people with dementia have a learning curve, unless it's again grossly severe. And then they do more poorly on their recall of that information. That's the way memory works. We don't see that general pattern here.

Q. So is this a pattern that you would see in a patient with mild to moderate dementia?

A. Absolutely not.

Q. Can you point to -- on your analysis here, this graph, for the Court what parts of this tell you that this is not a typical pattern for somebody with mild to moderate dementia?

A. Sure. Mr. Brockman's performance during the list-learning A, which is the immediate learning

10:31:58 trial, I provide three different -- I provided the
10:32:02 word list to him once, and he recalls as many words
10:32:06 as he can recall. And then I do it again, and he
10:32:08 does the same. And then I do it again, so it's
10:32:11 three times.
10:32:12 It's a learning process. His score
10:32:14 should have been higher than his delayed memory
10:32:18 score, but -- I mean, it is -- raw score is better
10:32:24 than zero, but that pattern is still not enough to
10:32:27 make it reasonable.
10:32:31 And the similar thing is the
10:32:34 pattern true as I mentioned on the story learning,
10:32:37 which is STL, IRC, versus his story learning DRC.
10:32:45 It's zero on both of them. That's not typically the
10:32:49 way it works.
10:32:52 We see -- actually, when you scale
10:32:54 that based upon norms, you can see looks atypical
10:32:58 because you can see the DRC portion there is higher.
10:33:01 It's a T of 30 versus a T of 19 on the first one.
10:33:06 It's atypical when you look at the norms to get that
10:33:09 sort of an uptick.
10:33:12 And last is the striking difference
10:33:14 between his verbal -- or his visual learning and
10:33:18 retention by those marks above the SHL -- the SHL
10:33:27 stands for shape learning. Now, you will see on

10:33:33 1 average an improvement for those, compared to the
10:33:36 2 verbal ones, but not this big of an improvement.
10:33:39 3 It's normal for me to see a bit of
10:33:42 4 an improvement across dementia cases, but not this
10:33:45 5 big of an improvement.
10:33:46 6 **Q.** So how do these scores -- specifically I want
10:33:49 7 to ask you about the shape learning, SHL score here.
10:33:53 8 Is that consistent with the Rey-15 Test we just
10:33:57 9 looked at where Mr. Brockman -- when was asked to
10:34:01 10 draw the shapes, A, B, C -- he only drew the circle,
10:34:04 11 are those two test results consistent?
10:34:07 12 **A.** No, but let me say a couple things. One is
10:34:12 13 that free recall rate of the Rey-15 is free recall,
10:34:15 14 not recognition, but it's exceedingly simple -- much
10:34:20 15 more simple than the tasks in the NAB® Memory
10:34:26 16 Module.
10:34:26 17 Second, no. These scores on the
10:34:33 18 NAB® Memory Module fall in the normal range.
10:34:37 19 Anything above a T of 40 is in the normal range,
10:34:44 20 because a T of 40 would be one standard deviation
10:34:48 21 below the mean. With mean scores the 50 and a ten
10:34:52 22 standard variation. So you can see that's below 50,
10:34:55 23 yes, but above 40 so that would be considered in the
10:34:58 24 normal range with the percentile rankings in the
10:35:02 25 20's, 30's and 40's.

10:35:04 **Q.** So just so we're clear, we're talking about the
10:35:06 two dots that -- on the graph that are -- the
10:35:10 mountain that peaks up; is that what we're talking
10:35:13 about?
10:35:13 **A.** Yes, SHL, IRG -- and SHL, DRG.
10:35:18 **Q.** Those pretty scores pretty much the same from
10:35:21 May to October?
10:35:22 **A.** Yeah, there was not any significant difference.
10:35:24 They were all within the normal range in May and
10:35:26 October.
10:35:27 **Q.** So in your professional opinion, an individual
10:35:30 who scored where that graph peaks up on this Memory
10:35:35 Module, is that consistent with what you saw in
10:35:39 Mr. Brockman's performance on the Rey-15 Test, the
10:35:43 test we just looked at?
10:35:44 **A.** No, absolutely not. He should have -- with
10:35:46 these high visual learning and retention scores, he
10:35:51 should have aced the Rey-15, particularly the
10:35:54 recognition portion. He should have done, like, 100
10:35:57 -- nearly virtually 100 percent.
10:36:00 **Q.** My question, Dr. Denney, is that inconsistency
10:36:02 that you just told the Court about -- what does that
10:36:05 tell you and inform your professional opinion about
10:36:08 Mr. Brockman?
10:36:10 **A.** That tells me that his memory performance, as

10:36:13 reflected on not only the NAB® Memory Module, but --
10:36:18 again the Rey-15 item and the other memory validity
10:36:23 tests indicate that his memory presentation is not
10:36:29 genuine. It's exaggerated.
10:36:34 MR. COREY SMITH: At this time I'm
10:36:35 going to go into a new area.
10:36:36 THE COURT: Good time for a break.
10:36:37 MR. COREY SMITH: If this is good for
10:36:39 the Court.
10:36:39 THE COURT: That'll be perfect.
10:36:40 15 minutes. I think that's been working well for
10:36:42 everyone. If you need a little bit more time, let
10:36:45 me know. But let's plan on being back in
10:36:47 15 minutes, which is ten till.
10:36:56 (Whereupon, a recess was held.)
10:58:54 THE COURT: Counsel, you may proceed
10:58:55 when ready.
10:58:56 MR. COREY SMITH: Thank you, Your
10:58:56 Honor. Before I restart the direct examination,
10:59:01 couple items I marked for identification, I'd like
10:59:04 to offer into evidence at this time. That would be
10:59:06 119, which is the ECST-R questionnaire. There were
10:59:13 the two graphs, 120 and 121 from Dr. Denney's
10:59:20 May 2021 examination.
10:59:22 THE COURT: Okay.

10:59:23 MR. COREY SMITH: And then there was
10:59:27 the last item, the test with the letters and the
10:59:30 numbers, 124, 125, and 126. I offer them into the
10:59:35 record at this time.
10:59:36 THE COURT: Okay. Any objection?
10:59:37 MR. LOONAM: No objection.
10:59:38 THE COURT: Without objection, 119,
10:59:40 121, 126 are admitted. Were one of those exhibits
10:59:44 the actual drawings -- or did you want --
10:59:48 MR. COREY SMITH: Yeah, the last one,
10:59:50 Your Honor, 124, 125, and 126.
10:59:53 THE COURT: Ah, 124, 125, and 126 are
10:59:58 all admitted.
10:59:58 MR. COREY SMITH: Thank you, Your
10:59:59 Honor.
10:59:59 MR. LOONAM: Your Honor, I would ask --
11:00:02 weren't part of the exhibit sets, so if you can
11:00:04 provide us a marked copy?
11:00:07 MR. COREY SMITH: Yes, we're making
11:00:08 copies and have them for you.
11:00:09 THE COURT: As long as you have a copy,
11:00:13 Mr. Loonam.
11:00:14 MR. LOONAM: I don't now, but it's
11:00:15 fine.
11:00:15 THE COURT: Do you need it at this

time?

MR. LOONAM: I don't.

THE COURT: Okay. You may continue.

MR. COREY SMITH: Thank you, Your Honor.

Q. So, Dr. Denney, I would like to ask you to compare your test-scoring results for Mr. Brockman from May to October. Is there anything you can draw from those two sets of scoring of cognitive testing and validity testing?

A. Well, they were very similar in both regards. The cognitive testing was -- results were extremely poor. The validity tests were positive overall.

Q. When you say the validity test was positive, what does that mean?

A. That out -- now, keep in mind there's multiple validity tests in any battery, and they don't all have to be positive. As I said, you don't look at just one test necessarily, although one test can be dispositive, but you look at the number of them together.

And on both of those assessments, Mr. Brockman failed two or more -- I don't recall. It may have been more, but anyways two or more of those validity tests. Research shows -- five

different studies since, gosh, over recent years have shown that when you have two or more validity test failures in a battery, even up to nine possible validity tests in that battery, two or more failed is a positive indicate orf overall test battery invalidity, meaning you cannot rely upon the clinical, cognitive testing as being a genuine reflection of the person's ability.

So in both of my assessments, May and October results suggested that Mr. Brockman was exaggerating, and in in my opinion intentionally exaggerating.

Q. You stand by your results not only in October, but also in May; is that correct?

A. Yes.

Q. Now, in addition to all of this testing that we've been talking about this morning, did you look at other data and other items in coming to your conclusions regarding Mr. Brockman?

A. You mean extra test material -- other items.

Q. Let me be more specific. Did you look at other doctors' testing and cognitive testing of Mr. Brockman in coming to your conclusions about Mr. Brockman?

A. Yes, I did.

11:02:49 **Q.** Are you familiar with a doctor by the name of
11:02:52 Dr. Michele York?
11:02:54 **A.** Yes.
11:02:54 **Q.** Did you review her test data?
11:02:56 **A.** Yes, I did.
11:02:57 **Q.** And her test reports? Let me ask you to go to
11:03:01 Government's Exhibit 82. It's in the binders there.
11:03:26 MR. COREY SMITH: This is a
11:03:27 pre-admitted exhibit, Your Honor.
11:03:30 **Q.** I would ask you at Exhibit 82, Dr. Denney, to
11:03:33 turn to Attachment O of that exhibit, it's deep in
11:03:37 the attachments.
11:04:00 **A.** Yes, I have it.
11:04:01 **Q.** So what is that?
11:04:03 **A.** This is a document entitled, "Confidential
11:04:06 Neuropsychological Evaluation Regarding Robert
11:04:11 Brockman by Dr. Michele York."
11:04:14 **Q.** What's the date of the test?
11:04:16 **A.** Oh, um, the date of evaluation was May -- I'm
11:04:22 sorry, March 1, 2019.
11:04:24 **Q.** Have you reviewed -- excuse me, have you
11:04:27 reviewed this -- these test results before?
11:04:29 **A.** Yes, I have.
11:04:30 **Q.** And what was Dr. York's conclusions regarding
11:04:35 Mr. Brockman?

11:04:38 **A.** That he had significant, cognitive problems and
11:04:42 warranted a diagnosis of dementia.
11:04:44 **Q.** Now, in reviewing Dr. York's report and test
11:04:48 data, do you know whether or not Dr. York performed
11:04:51 any of these validity tests that you have been
11:04:53 telling the Court about this morning?
11:04:57 **A.** Well, she evaluated him more than once.
11:05:01 **Q.** Well, we'll get to the other ones, but just
11:05:04 take them one at a time.
11:05:05 **A.** Okay. This is the first one in -- in March of
11:05:09 '19. No, she did not use any validity tests, and
11:05:11 she did not review what little embedded ability
11:05:17 tests were available.
11:05:18 **Q.** Yesterday, you were describing for the Court
11:05:21 yesterday the difference between a clinical
11:05:23 evaluation. Dr. York's evaluation in March of 2019,
11:05:27 was that a clinical or forensic evaluation?
11:05:29 **A.** It was a clinical evaluation in her clinic.
11:05:32 **Q.** So what does that mean to you as a forensic
11:05:38 psychologist -- psychological examiner?
11:05:40 **A.** That means that she came to the case with a
11:05:43 certain set of assumptions. As I tried to explain
11:05:49 yesterday, the differences between forensic and
11:05:53 clinical, one of the things are assumptions. You
11:05:55 assume the patient is there because they want to get

11:05:58 better, and you are assuming what they tell you is
11:06:03 reasonably true.
11:06:04 You do not assume that they have
11:06:06 any ulterior motivation, and then you respond in a
11:06:09 like manner with a therapeutic relationship. You
11:06:13 try to foster that so you can get the best testing
11:06:16 out of the person, and you are not particularly too
11:06:23 uptight about validity issues.
11:06:26 You know, you won't even
11:06:28 necessarily need to include validity tests.
11:06:30 **Q.** So in addition to -- you said -- well, let me
11:06:34 ask you this way. You said -- you are aware of
11:06:37 Dr. York evaluating Mr. Brockman more than once?
11:06:39 **A.** Yes.
11:06:39 **Q.** Did you review all of that test data and test
11:06:42 reports?
11:06:42 **A.** Yes, I did.
11:06:43 **Q.** How many times did she evaluate Mr. Brockman?
11:06:45 **A.** She evaluated him three times.
11:06:47 **Q.** And in those three times, what were -- were her
11:06:51 conclusions the same across all three tests or three
11:06:54 evaluations?
11:06:59 **A.** Yes, I believe they were. I believe she
11:07:03 reported that she believed he had dementia, and it
11:07:05 was dementia of the Lewy bodies type was her belief

it appeared.
Q. Do you recall the date of her second test? I don't know if that's in the exhibit, but do you recall the date of her second test?
A. I believe it was December of 2019.
Q. And do you know whether that was a forensic or clinical evaluation?
A. Well, she noted in her report that it had now shifted to a forensic evaluation because she had been requested by attorneys to perform the evaluation.
Q. And did -- did she perform, as far as you can recall, any validity testing in her December 2019 examination? I think you talk about that on Page 13 of your original report, if you want to refer to it.
A. Okay. Let me look at my report.
Q. It's your May report Page 13 you talk about Dr. York's testimony. That might help refresh your memory.
A. What was the exhibit number on that one?
Q. Number one?
A. Oh, you know, I've got it right here. I realized where I -- I've got it. There it is. Yes, I have -- I have it. I see it.
Q. So when Dr. York examined Mr. Brockman in

11:09:16 December 3rd of 2019, did she perform any validity
11:09:21 tests?
11:09:21 **A.** I believe she included the Rey-15-Item Test,
11:09:28 but she did not include the recognition portion.
11:09:31 She just did the first stimulus page. And she also
11:09:37 reviewed the Reliable-Digit Span embedded index.
11:09:44 **Q.** For Dr. York, how did Mr. Brockman perform?
11:09:48 **A.** On the Rey-15, he performed within acceptable
11:09:52 limits. His Reliable-Digit Span score was
11:09:58 acceptable as well, although there was other things
11:10:01 he did during the examination that raised some
11:10:03 serious concern about the validity of that exam.
11:10:06 **Q.** Serious concern with you or Dr. York?
11:10:07 **A.** With me.
11:10:09 **Q.** What are those things that he did?
11:10:12 **A.** In the December 2019 examination, during one
11:10:15 task she asked him to read down a list of words out
11:10:19 loud. He looked at one of the words and said,
11:10:25 "Well, that's not a word."
11:10:27 It was the word, "T-W-O."
11:10:32 **Q.** How would you interpret that response?
11:10:34 **A.** Well, that's ridiculous. These tests are
11:10:41 designed -- that test specifically is designed to
11:10:44 measure a person's pre-morbid level of ability. In
11:10:48 other words, it reaches through pathology and

captures old, well-learned information that a person would have had to such a degree that you can estimate what their pre-morbid, general psychometric intelligence would be.

So reading those words, that's old, well-learned information. He's been able to read the word "two" since probably in early elementary school or before. I mean, it's deeply ingrained. To lose that during extreme neuropathology, like a stroke or posterior cortical atrophy or some other very serious condition that we're not in any way talking about here, is ridiculous. Additionally, he claims he was unable to multiply three times four.

Q. What was Dr. York's conclusion in 2019 about Mr. Brockman's ability -- cognitive ability?

A. That was he was severely impaired. Still holding to the notion he had Lewy bodies-type dementia.

Q. Now, you mentioned the third examination by Dr. York; when was that?

A. I believe that was December of 2020 -- was it that late?

Q. If I can direct your attention to Page 15 of your report, I think that'll help refresh your memory.

11:12:20 **A.** I'm sorry, October of 2020, yes.
11:12:22 **Q.** Was this a forensic or clinical exam?
11:12:27 **A.** She again noted that it was at the request of
11:12:30 attorneys, and so noted it as a forensic exam. She
11:12:37 also noted it was in response to Dr. Pool.
11:12:39 So she's blurring clinical and
11:12:41 forensic in an inappropriate way, but noted it to be
11:12:46 some kind of forensic exam.
11:12:48 **Q.** So in her -- Dr. York's October of 2020 exam,
11:12:51 did Dr. York -- according to what you reviewed --
11:12:54 perform any validity tests?
11:12:57 **A.** She administered no free-standing validity
11:13:00 tests this time.
11:13:00 **Q.** So what does that indicate to you as the
11:13:03 reliability of this test data?
11:13:07 **A.** Well, without validity tests in a -- without a
11:13:15 thorough assessment of validity for a criminal
11:13:18 defendant who is a part of criminal proceedings, you
11:13:22 cannot rely on the -- the regular test data.
11:13:25 There's no way to say that that's valid.
11:13:29 **Q.** So did you -- well, let me back up to the --
11:13:33 the March 2019 test, which you talk about on Page 10
11:13:38 of your report. If I can ask you -- well, before I
11:13:42 direct you to an exhibit. In analyzing the data and
11:13:47 evidence in this case, were you made aware of two

depositions that Mr. Brockman gave in 2019?
A. Yes.
Q. One in January of 2019, and one in September?
A. September, correct.
Q. Did you review those transcripts?
A. Yes, I did. I believe the January -- well, I reviewed transcripts of the September deposition. I actually watched his video of the January deposition.
Q. And did you watching that video and reviewing of the January deposition, and reviewing the transcript of the September deposition -- did that inform your professional opinion you are giving the Court here today?
A. Yes, it did.
Q. And how is that? Well let me rephrase the question to make it clearer. What information did you glean from that review of those two depositions in formulating your professional opinion?
A. The doctors' test results suggesting dementia are erroneous. I teach my -- when I taught at -- in the neuropsych program at the Forest Institute teaching neuroanatomy and neuropathology, I always taught my students this phrase -- and my clinical interns as well -- real-world functioning always

trumps psychological test result.

In other words, your test result may say someone has no memory whatsoever, but when you see them in a deposition providing sharp responses with memory, and acting in a way that is totally opposite of what the severe test scores would suggest, you have to believe one or the other. And the real world should take precedence, not test scores, because test scores can be subverted intentionally or unintentionally.

Q. What did you observe from the January 2019 deposition on Mr. Brockman?

A. There is no way Mr. Brockman could have had dementia at that time. It's absolutely impossible given that performance.

Q. So that deposition was on January 16, 2019. What was the date of Michele York's 2019 examination, the exact date -- the date of her first examination?

A. March 1, 2019, I believe. At least in the report --

Q. Excuse me. So what is the lapse of time from the January 2019 deposition to Michele York 's first examination?

A. Six weeks.

11:16:34 **Q.** And you --
11:16:35 **A.** Or less.
11:16:36 **Q.** And you observed that tape, and you also
11:16:38 reviewed Dr. York's test data; is that correct?
11:16:40 **A.** Yes.
11:16:42 **Q.** So in your professional opinion, Dr. Denney,
11:16:45 could an individual that produced the test scores
11:16:50 that Mr. Brockman did for Dr. York -- could that
11:16:54 same person, six weeks earlier, have given that
11:16:59 performance you observed in the deposition in
11:17:01 January of 2019, just six weeks earlier?
11:17:06 **A.** No, absent some severe, intervening event, like
11:17:12 a major car accident, falling from a third floor --
11:17:16 story or something like that; right? Absent other
11:17:20 brain trauma, no.
11:17:22 Dr. York's memory testing, for
11:17:24 example, fell in the severe range -- the results
11:17:31 did. And there's no way that somebody with genuine,
11:17:36 severe range memory testing scores could have
11:17:38 performed the way he did just not even six weeks
11:17:43 later.
11:17:43 **Q.** When you viewed that videotape of Mr. Brockman
11:17:47 giving a deposition on January 16th of 2019, did you
11:17:51 see any indication of dementia of any sort exhibited
11:17:56 by Mr. Brockman during the deposition?

11:17:59 **A.** Not of dementia. Looking at it -- you know,
11:18:05 it's -- there were subtle signs. Of course, it's a
11:18:09 little different looking back on it. You know, I
11:18:12 may not have recognized it upfront, and certainly
11:18:15 without knowing the man before, but looking back on
11:18:17 them I can see subtle signs of possible
11:18:21 Parkinson's-type symptoms, but no indication of any
11:18:25 cognitive impairment whatsoever.
11:18:27 **Q.** And then, I want to ask you about Dr. York's
11:18:30 second exam on December 3, 2019. Did you review
11:18:34 this second deposition of the Defendant on
11:18:40 September 16th and 17th of 2019, the Federal Trade
11:18:44 Commission deposition?
11:18:46 **A.** Yes, I did.
11:18:46 **Q.** This one was not recorded, just reviewed the
11:18:49 transcript?
11:18:49 **A.** Correct.
11:18:50 **Q.** In your review -- reading of that transcript --
11:18:53 again, same question. Did you see any evidence of
11:18:56 mild to moderate or severe dementia -- dementia of
11:19:00 any kind?
11:19:01 **A.** Certainly nothing that would arise to dementia.
11:19:05 Not knowing whether the answers are corrector not, I
11:19:09 couldn't -- couldn't say that -- you know, they were
11:19:14 maybe incorrect. I don't know. His delivery of

them, phrasing, thought process, his ability to stay focused, his ability to handle the stress of that based upon his words on the transcript revealed no indication of a substantive, cognitive problem.

Q. So the timeframe from that deposition that you are talking about, September 2019, to Dr. York's exam in December of 2019, is roughly, what, two months, six to eight weeks?

A. Somewhere in there.

Q. In your professional opinion, could an individual that performed as you observed -- granted in a transcript -- then two months later produce the test results -- genuinely produce the test results that Dr. York recorded in her December 2019 evaluation?

Let me reverse that the other way. In December of 2019, I think you testified Dr. York determined that he is -- that Mr. Brockman is -- has moderate to severe dementia and incompetent to stand trial in December of 2019?

A. Yes.

Q. Could a person with those scores, just two months earlier, have performed as you observed in the transcript of that deposition in September of 2019?

11:20:34 **A.** Again, barring some drastic and serious
11:20:38 intervening event, no. Her -- her memory -- memory
11:20:42 scores -- summary index are about as low as they can
11:20:47 possibly get on the test -- literally on the bottom,
11:20:52 okay. And that's the same as it was, you know,
11:20:56 months and months before.
11:20:58 And to have these interjected
11:21:01 depositions in there, no, it makes no sense. The
11:21:04 test cannot possibly be a genuine reflection of his
11:21:08 real abilities.
11:21:08 **Q.** In light of the deposition?
11:21:09 **A.** In light of the depositions. It's impossible.
11:21:12 **Q.** So on Page 17 of your report, you again talk
11:21:15 about some other doctors performing some tests.
11:21:20 Specifically I want to ask you about Mr. Brockman's
11:21:23 office visits with Dr. Lai. I guess Dr. Lai,
11:21:34 according to this, examined him three times?
11:21:38 **A.** I believe so, but this is the June report;
11:21:42 right?
11:21:42 **Q.** Yes.
11:21:42 **A.** Dr. Lai, I believe, evaluated him after this
11:21:47 report.
11:21:47 **Q.** I'm going to ask you about what's in this
11:21:49 report.
11:21:49 **A.** Very good. Yes.

11:21:50 **Q.** Let me start -- let's start with this. We'll
11:21:53 get to that in a minute. Did you review these
11:21:55 medical records and these analyses?
11:21:57 **A.** Yes, I did.
11:21:58 **Q.** What did Dr. Lai determine in his analysis or
11:22:03 his evaluation of Mr. Brockman?
11:22:07 **A.** It's my recollection that he opined that
11:22:11 Mr. Brockman had some mild cognitive problems,
11:22:16 probably with mild cognitive impairment, which he
11:22:19 attributed to Parkinson's, but he also raised the
11:22:22 possibility of REM sleep behavior disorder.
11:22:25 **Q.** What is that?
11:22:28 **A.** REM sleep behavior disorder is -- because of
11:22:32 pathology in the brain, it causes the typical
11:22:37 circadian rhythms in the way the brain functions
11:22:41 during the day and night to alter to where people,
11:22:44 while they're sleeping, tend to act out their
11:22:47 dreams. The part of the brain that shuts down the
11:22:50 body from motor movement during those deep-sleep
11:22:53 dreams becomes faulty, and a person starts to
11:22:57 physically act out their dreams.
11:22:59 It's oftentimes -- or it's -- it's
11:23:01 one of the characteristics inherent in Lewy
11:23:04 bodies-related dementia.
11:23:06 **Q.** Is this symptom recorded in Dr. Lai's reports?

11:23:15 **A.** Well, he noted that there had been reported
11:23:19 symptoms that suggested REM sleep behavior and --
11:23:23 and -- and medication had been prescribed for that.
11:23:26 **Q.** Is that REM sleep disorder attributable to a
11:23:31 particular disease?
11:23:32 **A.** Well, it's -- it's very commonly associated
11:23:35 with Lewy bodies disease.
11:23:39 **Q.** What is Lewy bodies disease?
11:23:41 **A.** Lewy bodies disease is closely related to
11:23:49 Parkinson's disease. Lewy bodies are abnormal brain
11:23:55 cells -- damaged brain cells, in essence -- that
11:23:59 have been termed Lewy bodies because it refers to
11:24:02 being identified by Lewy.
11:24:07 And they are reflected in -- in the
11:24:10 brain in a greater amount in Parkinson's, but -- and
11:24:14 even more severe manner in Lewy bodies dementia.
11:24:18 **Q.** So in your review of these medical records from
11:24:23 Dr. Lai, Dr. York, and some of the other doctors
11:24:26 that the Defendant went to, did you observe that the
11:24:30 Defendant had relayed to his doctors that he had the
11:24:34 symptoms of Lewy bodies disease, like this acting
11:24:36 out --
11:24:37 MR. LOONAM: Objection to this leading,
11:24:38 Your Honor.
11:24:42 THE COURT: I'm going to allow it, just

so I can -- we can keep moving forward. I think this is in the expert report, so it's already out there. So I'm going to allow it. Objection overruled.

MR. COREY SMITH: Just two questions on this issue and then move on, Your Honor.

Q. I just wanted to ask if -- in your review of the medical records, did the Defendant report to some of his doctors some of these symptoms of Lewy bodies disease?

A. That's what the report said. That's -- that's, like, Dr. Lai for example that's why he suggested the possibility of that because of the report of Mr. Brockman and I think Mrs. Brockman.

Q. The second question is in viewing the more recent medical evidence in this case, is there any evidence that the Defendant has Lewy bodies disease?

A. No, I believe that has been pretty well put to rest that he does not have dementia -- the Lewy bodies type.

Q. So back to Dr. Lai's report. I want to ask you in your review of his analysis and report, did Dr. Lai perform any validity tests on Mr. Brockman?

A. No.

Q. Now, are you familiar with the more recent --

11:25:47 you started to bring it up, the more -- it's not in
11:25:50 your report -- the more recent examination of the
11:25:53 Defendant by Dr. Lai; did you review that?
11:25:55 **A.** Yes, I did.
11:25:56 **Q.** What does Dr. Lai conclude in that report?
11:26:00 **A.** He concluded that doctor -- Mr. Brockman's
11:26:04 condition has worsened to such a degree now that --
11:26:07 based upon the reports of, you know, his wife and I
11:26:13 believe caregiver that his condition now would
11:26:17 warrant the diagnosis of dementia.
11:26:22 **Q.** These evaluations by Dr. Lai, were these
11:26:25 clinical or forensic evaluations?
11:26:26 **A.** Those were clinical evaluations, yeah.
11:26:28 **Q.** Did Dr. Lai perform any validity tests in his
11:26:31 most recent examination?
11:26:32 **A.** No.
11:26:41 **Q.** Now, you mention that Dr. Lai's report is based
11:26:46 on reports from Mrs. Brockman and Mr. Brockman's
11:26:54 caregiver; is that right?
11:26:56 **A.** I'm not 100 percent positive that he -- he
11:26:58 obtained information from Mr. Gutierrez; right --
11:27:04 Frank. My recollection is he did. He definitely
11:27:08 obtained information from Missus and Mr. Brockman.
11:27:11 **Q.** Let me ask you about your evaluations of
11:27:13 Mr. Brockman, Dr. Denney. Normally, when you

perform an evaluation like this of a defendant in a criminal case -- or any subject -- do you normally seek to interview people close to the subject to -- to get a recording of their observations of the subject?

A. Yes, I do.

Q. Did that happen in this case?

A. No.

Q. You didn't talk to anybody close to Mr. Brockman?

A. No, I did not.

Q. Why not?

A. Well, I wanted to. We had talked about the possibility of us being able to do that. And I was told that they chose -- for example, Mrs. Brockman chose not to be interviewed by me.

Q. So that was not your choice not to interview anybody?

A. No.

Q. So, in addition -- going through the list of things that you looked at to come to your professional opinion about Mr. Brockman's condition, we've talked about your testing. You reviewed other medical records of other doctors. You looked at the depositions.

11:28:26 Are you aware of some speeches that
11:28:30 Mr. Brockman gave in 2019?
11:28:34 **A.** Yes.
11:28:36 **Q.** And specifically a speech in 2018 to a set of
11:28:43 Reynolds and Reynolds employees?
11:28:45 **A.** Yes, he was speaking at the Reynolds and
11:28:48 Reynolds birthday celebration, a yearly event.
11:28:51 MR. COREY SMITH: So we're prepared to
11:28:52 play a three or four-minute clip of this. It's
11:28:55 Exhibit 116. This clip will be marked for
11:28:57 identification 116-A, if that's okay, Your Honor.
11:29:00 THE COURT: 116-A, of course, is
11:29:02 admitted.
11:29:05 MR. COREY SMITH: Entire tape is
11:29:07 pre-admitted.
11:29:11 (Whereupon, audio played and not reported.)
11:31:00 So could we go to the very beginning of
11:31:03 the actual exhibit -- just to get the date of this
11:31:05 speech? It's -- I think it's imprinted on the tape.
11:31:40 (Whereupon, audio played and not reported.)
11:31:52 **Q.** Doctor, do you know when this speech was given?
11:31:55 **A.** I believe December of 2018, yeah.
11:31:59 **Q.** So what I want to ask you is to compare what we
11:32:02 just saw Mr. Brockman -- at least that clip of his
11:32:05 speech in 2018, November/December of 2018 -- to the

11:32:11 test results and the evaluation of Mr. Brockman by
11:32:14 Dr. York on March 1st of 2019, three or four months
11:32:19 later.
11:32:20 In your professional opinion, could
11:32:23 an individual that tested the way Mr. Brockman
11:32:26 tested with Dr. York on March 1, 2019, have given
11:32:31 the performance just four months earlier we just saw
11:32:37 [SIC] on that tape?
11:32:40 **A.** Again, not with -- with a couple caveats, the
11:32:43 answer is no. But the caveats are -- you know,
11:32:47 assuming no intervening event happened, no car
11:32:51 accident or parachute not opening or something in
11:32:54 that intervening time, and in the context of the
11:32:57 type of neuropathologies we're talking about here,
11:33:04 no. There are some degenerative conditions and an
11:33:07 illness that a person can have that can cause a
11:33:10 crash and burn in just three months for sure, but
11:33:12 that's not the situation here.
11:33:15 So regarding Mr. Brockman, no.
11:33:18 There's no way.
11:33:19 **Q.** And then, are you also aware of a similar
11:33:21 speech Mr. Brockman gave the following year? That's
11:33:24 Exhibit 77, Your Honor. We have another short clip
11:33:27 -- another three minutes. We'll mark that clip
11:33:31 77-A.

11:33:38 (Whereupon, audio played and not reported.)

11:36:45 MR. COREY SMITH:

11:36:46 **Q.** Dr. Denney, do you know the -- we said the year
11:36:49 is 2019. Do you know the month this speech was
11:36:52 given?

11:36:52 **A.** November, I believe.

11:36:54 **Q.** Is there anything notable about Mr. Brockman's
11:36:58 speech -- at least that clip -- in light of his
11:37:02 evaluation -- the evaluation of his cognitive
11:37:04 abilities; anything that you noted?

11:37:08 **A.** Yes, two things first that I need to mention is
11:37:10 we see a difference between this and the earlier in
11:37:13 his physical presentation. That difference I would
11:37:19 attribute to early signs of Parkinson's-type thing.
11:37:23 Little less facial animation, but we can't let the
11:37:29 physical signs of Parkinson's confuse us when we're
11:37:33 talking about cognitive functioning because they're
11:37:35 different.

11:37:36 His cognitive functioning was --
11:37:39 was good. He was using notes obviously, but then he
11:37:45 separated from his notes and he was able to
11:37:46 communicate what he wanted to communicate from his
11:37:48 own mind/memory. He did well.

11:37:51 Comparing that to the tests -- is
11:37:53 that what you asked; right?

11:37:55 **Q.** That was my next question. I want to ask you
11:38:00 to compare your observations in November of 2019, to
11:38:03 the test results that Dr. York recorded just the
11:38:05 next month on December 3rd of 2019.
11:38:09 **A.** Right. And this was -- the video, if I recall
11:38:12 correctly, was like the 13th or 14th. It's
11:38:15 somewhere in the early/mid-portion of November. And
11:38:18 now, you know, less than a month later he is scoring
11:38:22 in the most severest range possible on learning and
11:38:27 memory testing. That's -- that defies credulity.
11:38:34 **Q.** So in light of this evidence of the speeches,
11:38:40 your observation and analysis of the depositions --
11:38:42 all in 2019 -- what does that tell you about the
11:38:46 reliability of Dr. York's conclusions -- with all
11:38:51 due respect to Dr. York, what does that tell you
11:38:54 about the conclusions she reached in her reports?
11:38:56 **A.** They are wrong.
11:39:04 **Q.** Now, like to change gears for a second and move
11:39:06 to Dr. Guilmette. Did you have an opportunity to
11:39:08 review Dr. Guilmette's initial report in July of --
11:39:12 in -- regarding his July 2021 evaluation of
11:39:18 Mr. Brockman?
11:39:18 **A.** Yes, I did.
11:39:20 **Q.** And it's actually Defense Exhibit 21, which I'm
11:39:23 -- if I may approach the witness, Your Honor?

11:39:25 THE COURT: You may approach.
11:39:26 MR. COREY SMITH:
11:39:26 **Q.** If you don't have it, his reports are in here
11:39:29 -- I don't know -- you got a lot right there. There
11:39:32 you go.
11:39:33 **A.** That's all right. I know where to find it.
11:39:35 **Q.** It's Exhibit 21.
11:39:36 **A.** Okay.
11:39:40 **Q.** I'll give you a second to get to your report.
11:39:47 **A.** 21 is a -- is a transcript.
11:39:52 **Q.** I'm sorry, is it maybe 22?
11:40:09 **A.** Probably 20.
11:40:15 **Q.** 19. I'm sorry. It's Exhibit 19 -- Defense
11:40:21 Exhibit 19.
11:40:42 **A.** That says August 6th, '21.
11:40:47 **Q.** That would be when the report was submitted?
11:40:49 **A.** That's -- okay. Yes, right. That's July's
11:40:51 examination, then. Yes.
11:40:52 **Q.** Yes. So what I want to ask you -- and you
11:40:55 commented in your supplemental report about
11:41:00 Dr. Guilmette's first report. It's on Page 4 of
11:41:06 your supplemental report?
11:41:10 **A.** Yes.
11:41:11 **Q.** So what I want to ask you is what we've been
11:41:14 talking about, Dr. York's reports, does

Dr. Guilmette in his report state he is looking at and relying on Dr. York's reports?

A. Oh, yes. He listed, as a source of information, Dr. York's reports. He also discusses it in his report, those findings.

Q. Does he come to the same conclusion that you do that Dr. York's conclusions are wrong?

A. No, he gives no indication in his report that he has any suspicion of the genuineness of those findings.

Q. Does -- in your review of Dr. Guilmette's report from July, submitted in August of '21 -- does Dr. Guilmette review or comment on -- well, let me take away review, because I think they're listed, but does he comment on what we've looked at and talked about here in this courtroom today, Mr. Brockman's 2019 depositions in January of 2019, or December of 2019?

A. The report does list them that he -- that -- that they were sources of information for him, but I don't believe he comments on them, in any way, in the report. He certainly doesn't integrate them into his opinion, seemingly.

Q. Does he compare those 2019 depositions to Dr. York's evaluations of Mr. Brockman, which were

basically contemporaneous?
A. There's no indication of that.
Q. Does -- in your review of Dr. Guilmette's report, does he comment on the speeches that Mr. Brockman gave in November of 2018 and November of 2019 that you reviewed?
A. To the best of my recollection, no.
Q. Now, in Dr. Guilmette's report on Page 22, if I can ask you to turn to that, this is his initial report, not the supplemental report?
A. Yes.
Q. He talks about Dr. York's evaluations of Mr. Brockman; is that right?
A. Yes.
Q. What does he find?
A. Well, he discusses the fact that Dr. York administered certain tests, and that she changed to a -- from a clinical evaluation to a forensic evaluation, and that she administered a malingering test.

He noted that might explain why he seemed to have done better on the second exam is because she told him it was a forensic exam.
Q. Does -- does Dr. Guilmette, in his report talking about Dr. York's evaluations, at all

11:44:17 question the reliability of Dr. York's conclusions
11:44:23 or does he accept them at face value?
11:44:26 **A.** Well, he mentions that she performed validity
11:44:30 indications -- or assessment to some degree, but he
11:44:33 didn't say anything critical of it. He -- he
11:44:36 appeared to accept it as -- them as being valid
11:44:39 findings.
11:44:39 **Q.** And in discussing the various scoring that
11:44:46 Dr. York did -- I mean, this is Dr. Guilmette
11:44:49 discussing Dr. York's findings -- does he make a
11:44:52 comment about the consistency of the scores over
11:44:57 time?
11:44:57 **A.** Yes, he does. I think that's in the context of
11:45:01 the notion of malingering or validity.
11:45:03 **Q.** So what does Dr. Guilmette say in his report?
11:45:05 **A.** Yeah, my recollection is he was saying because
11:45:08 the tests are consistent across time, that that
11:45:12 supports the notion that they are valid.
11:45:15 **Q.** Do you agree with that conclusion?
11:45:16 **A.** No.
11:45:17 **Q.** Why not?
11:45:18 **A.** Well, you can have consistent, invalid results.
11:45:22 It's just like shooting an arrow at a target. You
11:45:25 can consistently miss the target. That doesn't make
11:45:28 it accurate. That's one aspect of it conceptually.

11:45:38 When a person exaggerates and
11:45:40 starts suppressing their scores down, the scores
11:45:43 tend to cluster together, because they hit a floor
11:45:47 effect. They can only go so bad, and you translate
11:45:50 the raw scores into scaled scores and other standard
11:45:54 scores.
11:45:54 In that process, they get scrunched
11:45:57 into little categories. And that squishes them down
11:46:00 when they're at the very low end of the performance
11:46:02 ability of the test. Consequently, the summary
11:46:07 indices then come out looking very, very similar.
11:46:11 Just because somebody is producing scores in a -- in
11:46:15 an impaired range on a consistent basis in no way
11:46:21 supports the notion that they're valid.
11:46:23 **Q.** To be clear, when we're talking about comparing
11:46:25 scores, we're talking about Dr. York's scores; is
11:46:28 that right?
11:46:28 **A.** Yes, in this context here of -- of
11:46:31 Dr. Guilmette discussing Dr. York, yes. Because she
11:46:34 had three different testing sections.
11:46:36 **Q.** He's accepting the scores as valid as written?
11:46:40 MR. LOONAM: Objection to leading, Your
11:46:42 Honor.
11:46:42 MR. COREY SMITH: I can rephrase.
11:46:43 THE COURT: Rephrase.

MR. COREY SMITH:

Q. Is Dr. Guilmette, in his analysis, accepting Dr. York's scores as valid as written?

A. In my opinion, Dr. Guilmette says that they're valid. He doesn't -- he doesn't give any indication he thinks they're invalid, and appears to be supporting them and relying on them as a valid reflection of the man's real abilities.

Q. In your opinion, Dr. Denney, with an individual that actually has dementia, who has tested over a period of time over almost two years, what would you expect to see in terms of these cognitive scores? Well, go ahead. Answer that question.

A. These conditions are well known. We understand how they work. We understand what's called the natural course of the disorder. For instance, Alzheimer's disease; right? It starts usually -- the standard Alzheimer's type of disease starts with memory difficulties upfront. That can go for several years.

Then there's a diagnosis. The average length of time for a diagnosis to death is eight to ten years, but it can be as long as 20 years. That's what the research shows. And we know that a person is just mildly affected early on,

but as time goes by they start to have more problems and more problems.

So we see a curve in their performance, their memory scores, for example, are maybe a little bit impaired, maybe one or two scores fall in the mild one standard deviation below maybe. So you might say, "Okay, this would warrant mild cognitive impairment," because they're perceiving the problems, but it's not affecting their lives in a substantial way.

The scores get worse, and worse, and worse over time. We see the natural course of the disorder play out as it does. That's science. That's true for Parkinson's-related -- they're neurodegenerative diseases, so they gradually get worse over time.

You don't see the worst possible scores early in the course of the disease, and the worst possible scores late in the course of the disease. That's not how it works.

Q. So do you agree or disagree with Dr. Guilmette's conclusions regarding observing Dr. York's scores over time?

A. Well, his -- his conclusion is that they were consistent over time, but that -- they shouldn't

11:49:24 have been consistent over time. If he really had --
11:49:27 if he was presenting in a genuine way to providers
11:49:32 early on when his -- when his problems are just
11:49:34 starting to arise, then we're going to see scores
11:49:37 that are reasonably good but maybe faulty. Then
11:49:44 over time they're going to gradually get worse.
11:49:47 We don't see that here. We see a
11:49:49 straight line, severe memory performance, from the
11:49:54 earliest performance with Dr. York to her assessment
11:49:57 two years later.
11:50:00 MR. LOONAM: Your Honor, if we can take
11:50:02 a break at a convenient time for counsel in
11:50:05 questioning?
11:50:05 THE COURT: Sure.
11:50:06 MR. LOONAM: Thank you, sir.
11:50:08 THE COURT: Not a problem. Would you
11:50:10 like -- good stopping point right now?
11:50:13 MR. COREY SMITH: We can stop right
11:50:14 now. I was going to into a new subject matter.
11:50:17 MR. LOONAM: I got lucky --
11:50:18 THE COURT: How long do you need?
11:50:19 MR. LOONAM: -- before I interjected.
11:50:21 THE COURT: About how long?
11:50:22 MR. LOONAM: Just a few minutes, Your
11:50:24 Honor.

11:50:24 THE COURT: Okay. Is ten minutes Okay.
11:50:27 And then continue on until about 10:30.
11:50:31 MR. LOONAM: Thank you, Your Honor.
11:50:33 THE COURT: We'll take a break until
11:50:35 12:00 noon and then get started then.
11:59:16 (Whereupon, a recess was held.)
12:05:39 THE COURT: You may continue.
12:05:41 MR. COREY SMITH: Thank you, Your
12:05:41 Honor.
12:05:41 **Q.** Before the break, Dr. Denney, I asked you
12:05:44 questions about comparing Dr. York's evaluations
12:05:48 over time and Dr. Guilmette's conclusions about that
12:05:53 comparison, as compared to your conclusions. I want
12:05:55 to go back to you -- if you could go -- I want to go
12:05:59 back to those Dr. York reports to make sure the
12:06:02 record is clear. Could you put in front of you
12:06:04 again Government's Exhibit -- it's 82 -- yeah, 82,
12:06:11 and ask you to look at Dr. York's reports again.
12:06:14 Yeah, 82.
12:06:15 Exhibit A of Exhibit 82 I believe is
12:06:24 Dr. York's December report.
12:06:31 **A.** December 3, 2019, yes.
12:06:33 **Q.** Yes. So what is her conclusion about
12:06:36 Mr. Brockman in December 2019?
12:06:47 **A.** Um --

12:06:48 **Q.** I believe it's towards the end.
12:06:51 **A.** Yeah, I'm looking at the last paragraph now. She lists these difficulties taken together with dementia at the time of diagnosis -- basically she's concluding he has dementia with Lewy bodies.
12:07:04 **Q.** What severity of dementia does she conclude?
12:07:14 **A.** I don't recall that off the top of my head. Let me see if I can find where she says that.
12:07:18 **Q.** Direct you to the last page of her report where she signs it.
12:07:21 **A.** That's where I'm looking it.
12:07:23 **Q.** It's up on the screen.
12:07:24 **A.** Oh, I'm sorry.
12:07:30 **A.** Mild to moderate severity, based upon the test results.
12:07:36 **Q.** And then, if you could go to Exhibit O of that Exhibit 82, which is her March report.
12:07:42 **A.** Yes.
12:07:56 **Q.** And what does she conclude in March?
12:07:56 **A.** Let's see. You've got it there, I've got it here. Again, she concludes consistent with dementia with Lewy bodies.
12:08:11 MR. LOONAM: Do we know which page the witness is referring to?
12:08:16 MR. COREY SMITH: Page 69 of Exhibit O

12:08:30 to Exhibit 82.

12:08:34 THE WITNESS: Yeah, 69 and 70 at the
12:08:36 top and on the top of the next page. She says at
12:08:40 the top of 70 -- I'm trying to find if she qualifies
12:08:48 that at all to a severity level.

12:09:06 **Q.** Towards the bottom of Page 69, Dr. Denney.

12:09:09 **A.** Oh, I see. There we go. "Pattern of
12:09:12 neuropsych performance indicates dementia of mild to
12:09:15 moderate severity" -- same thing.

12:09:17 **Q.** Do you agree with either one of these
12:09:19 conclusions?

12:09:22 **A.** Well, I mean, if you take that sentence by
12:09:25 itself, I agree that the neuropsych tests's scores
12:09:28 could be consistent with mild to moderate, but I
12:09:31 don't agree with her conclusions, given the total of
12:09:34 the information available.

12:09:39 **Q.** Including some of the things --

12:09:41 **A.** Right, the videos, decision -- that sort of
12:09:43 thing.

12:09:43 **Q.** Is there any indication -- are you aware of
12:09:45 Dr. York -- based on her report that she considered
12:09:48 any of that other evidence?

12:09:49 **A.** There's no indication she was even aware of
12:09:52 them, or -- yeah. No, nothing.

12:09:55 **Q.** So let's -- you can set that aside if you want,

12:10:00 Dr. Denney. I want to go back to your supplemental
12:10:02 report where you're discussing Dr. Guilmette's
12:10:04 findings.
12:10:09 While you're doing that, I want to
12:10:11 ask you are you aware whether or not Dr. Guilmette
12:10:14 performed any validity tests like we were talking
12:10:17 about all this morning?
12:10:19 **A.** Yes, he did.
12:10:20 **Q.** Did you evaluate those validity tests performed
12:10:24 by Dr. Guilmette?
12:10:25 **A.** Yes, I had the opportunity to review the raw
12:10:28 test data.
12:10:29 **Q.** So I want to ask you -- Page 5 of your
12:10:33 supplemental report of October of this year, you
12:10:35 discuss the validity tests performed by
12:10:38 Dr. Guilmette; do you see that?
12:10:40 **A.** Yes.
12:10:41 **Q.** And just going to go through -- well, first of
12:10:44 all, from a global perspective did Mr. Brockman fail
12:10:50 any of Mr. Guilmette's validity tests like he did
12:10:54 with you?
12:10:54 **A.** Yes, he failed more than one.
12:10:58 **Q.** What does that indicate to you, in your
12:11:00 professional opinion?
12:11:03 **A.** Well, he failed enough of them to indicate that

12:11:07 the rest of the neurocognitive test data are not a
12:11:10 valid reflection of his genuine, cognitive ability.
12:11:14 **Q.** Did Mr. Guilmette, in his report, come to that
12:11:20 same conclusion?
12:11:21 **A.** No, he did not.
12:11:22 **Q.** What did Mr. -- Dr. Guilmette conclude?
12:11:25 **A.** Dr. Guilmette -- it appeared to me that he was
12:11:28 rationalizing away the positive findings on the
12:11:31 validity tests.
12:11:32 **Q.** Let's go through a couple of those validity
12:11:34 tests. The first one is the MSVT test. You talk
12:11:38 about it in your report on Page 5 -- your
12:11:41 supplemental report, Exhibit 2?
12:11:43 **A.** Yes.
12:11:44 **Q.** What is your conclusion -- first of all, the
12:11:49 MSVT validity test, did you administer that test to
12:11:54 Mr. Brockman?
12:11:54 **A.** I did in October of 2021.
12:11:56 **Q.** Did Mr. Brockman fail or pass that test?
12:11:58 **A.** In my opinion, he failed it.
12:12:03 **Q.** And why do you -- when you say in your opinion?
12:12:06 Was there -- is it a -- some --
12:12:08 **A.** Well, there's no hesitation with that. It's
12:12:10 just -- yes, I believe he failed it.
12:12:12 **Q.** Okay. What about when Mr. -- Dr. Guilmette

12:12:16 administered the same test? What does Dr. Guilmette
12:12:20 record happened?
12:12:22 **A.** Dr. Guilmette rightfully noted that it was a
12:12:26 fail, but then looking at the simple algorithm
12:12:32 between the easy/hard items, it met that rule. So
12:12:36 it would be a possible, genuine memory impaired
12:12:40 profile. And then he left it at that.
12:12:42 He said -- he wrote because it's a
12:12:45 genuine, memory impaired profile that substantiates
12:12:50 -- in essence substantiates Mr. Brockman's
12:12:54 impairment, and not indicating that it would reflect
12:12:57 invalidity.
12:12:59 **Q.** So does Dr. Guilmette conclude this is a pass?
12:13:03 **A.** Yeah, he -- he -- he treats it as a pass.
12:13:05 **Q.** Would you agree with that?
12:13:07 **A.** Well, I wouldn't based upon research data.
12:13:14 **Q.** Okay.
12:13:15 **A.** Specific --
12:13:16 **Q.** I'm sorry. Did you want to expand that answer?
12:13:19 **A.** Yes, specifically the reason I say that is
12:13:21 because the easy subtests were so much lower than
12:13:30 what we would expect with dementia. They were so
12:13:34 low that -- and people have researched this now and
12:13:37 published on it in 2021, Cerny and colleagues came
12:13:41 out with a -- a -- an insightful point that if the

12:13:46 easy subtests are so low compared to genuinely,
12:13:52 cognitively impaired persons, then it's not really a
12:13:55 plausible profile. And they took the average of the
12:13:57 three easy tests to get that mean. If a mean score
12:14:01 is less than 75 for those three easy tests, that's
12:14:05 considered a fail in their clinical data. That's
12:14:10 what they recommended using.
12:14:17 The mean score for Dr. Guilmette's
12:14:19 MSVT done in July was 73, which is below that
12:14:24 seventy five, but that's a relatively new finding.
12:14:30 And I wanted to verify that that really is a
12:14:33 valuable tool. And so, I took out of -- data set of
12:14:44 dementia patients with the MSVT that I -- that Katy
12:14:46 Dunham (phonetic) and I, and some other colleagues
12:14:48 published on several years ago.
12:14:50 These are MSVT data acquired from
12:14:54 demented patients in nursing homes, okay. I then
12:14:59 compared Mr. Brockman's MSVT easy score obtained
12:15:07 during Dr. Guilmette's assessment in July of 2021 to
12:15:17 nursing home patients. Mr. Brockman's was
12:15:19 significantly lower than the nursing home patients
12:15:23 on the easy portion of the MSVT, which are the
12:15:26 validity aspects of the MSVT.
12:15:30 Consequently, I believe that data
12:15:33 supports the Cerny et al findings that if you have

12:15:37 an unusually low mean score in the easy subtests of
12:15:40 the MSVT that that is still a fail because it is an
12:15:45 implausible profile. And that's -- the notion of
12:15:53 implausible profile has been long known and promoted
12:15:58 by Paul Green.
12:15:59 **Q.** When someone fails validity test like this
12:16:01 because of the implausible profile, what does that
12:16:03 tell you about the reliability of the overall,
12:16:06 cognitive testing?
12:16:06 **A.** Well, again, just looking at one test may not
12:16:10 be completely fair because you want more than one
12:16:13 failed validity test in a battery. But looking at
12:16:16 that one test, that would suggest the other
12:16:18 neurocognitive test data were not a valid reflection
12:16:21 of his genuine abilities, but I would would need to
12:16:25 look at the other validity tests, too.
12:16:26 **Q.** Let's look at another one of Dr. Guilmette's
12:16:30 validity tests, the Rey-15 Test, which you also
12:16:35 discuss on Page 15 of your supplemental report. Do
12:16:37 you agree with Dr. Guilmette's conclusions on the
12:16:39 Rey-15 Test that he passed -- that Mr. Brockman
12:16:41 passed that validity test?
12:16:43 **A.** I do not. I definitely do not agree with him
12:16:45 on that.
12:16:45 **Q.** Why is that?

12:16:47 **A.** Dr. Guilmette did something that was -- which I
12:16:53 would say is not kosher regarding a validity test.
12:16:59 He administered it, and Mr. Brockman failed it. He
12:17:05 then coached Mr. Brockman to perform it again, at
12:17:10 which point he passed it, per Dr. Guilmette's
12:17:16 interpretation.
12:17:17 And, um, number one I don't believe
12:17:20 that's right. You are not supposed to do that. You
12:17:23 don't coach people on validity tests. In addition,
12:17:26 when you look at the algorithm produced by Fazio,
12:17:38 Faris and Yamout, which is a paper Dr. Guilmette
12:17:44 cited in his own report, when you look at their rule
12:17:46 for evaluating a Rey-15-Item Test's validity among
12:17:50 elderly with cognitive impairment, he still fails.
12:17:52 He gets a score on that of -- what
12:17:56 was it? Oh, a zero. It takes the true positives,
12:18:03 minus the false positives, minus the intrusions and
12:18:05 got a zero. And that's below two, which is the
12:18:07 cutoff in that research.
12:18:08 **Q.** So is that two validity tests that you believe
12:18:13 Mr. Brockman failed --
12:18:13 **A.** MSVT and the Rey-15? Yeah, he failed.
12:18:15 **Q.** Now, you also talk about test called the
12:18:20 Coin-in-the-Hand-Test that Dr. Guilmette
12:18:22 administered to Mr. Brockman. Can you explain to

12:18:26 the Court what the Coin-in-the-Hand-Test is?
12:18:29 **A.** Yes. The Coin-in-the-Hand-Test -- we're
12:18:33 talking about July; correct?
12:18:34 **Q.** July 1st.
12:18:35 **A.** Yes.
12:18:36 **Q.** July 1st testing.
12:18:38 **A.** Sure. The Coin-in-the-Hand-Test is a validity
12:18:41 test that was developed with the notion of using it
12:18:44 with substantially, cognitively impaired people,
12:18:48 potential dementia cases where there is some
12:18:52 suspicions whether that's really valid or not.
12:18:55 The way the test works is you hold
12:18:58 a nickle -- you have a nickle and you tell the
12:19:00 examinee that, "Okay. I have this nickle and I'm
12:19:03 going to put it in one of my hands, and then I want
12:19:06 you, with your eyes open, to watch me do it. Then I
12:19:09 want you to close your eyes and count backwards from
12:19:12 ten, and open your eyes and tell me which hand it is
12:19:16 in."
12:19:17 Okay. It's exceedingly simple.
12:19:22 For people who don't have substantive, cognitive
12:19:25 problems, and who are rather intelligent probably,
12:19:32 can see through it rather easily. Nonetheless, it
12:19:34 has been known to be a viable indicator when
12:19:37 somebody scores more than two errors out of ten

trials on that simple task.

Q. Before Dr. Guilmette, did Mr. Brockman pass that test?

A. He did. I think he got all ten right.

Q. What does that indicate to you?

A. Not much.

Q. What about in October, when Dr. Guilmette examined Mr. Brockman again did Mr. Brockman pass that test or fail that test?

A. Dr. Guilmette administered the same task in October, and this time Mr. Brockman failed it. He produced three errors on it, which is more than two and that's a fail.

Q. And there's another test in your report that you talk about, the A Test; what's that?

A. Yes. The A Test is an old, mental status-related task that has been adopted for use in detecting -- it's been adopted for use as a validity test for people with cognitive impairment. And you -- you -- the examiner reads a list of letters, and the examinee has to tap their hand or their finger every time the letter A comes up on the list.

And if the person has more than two errors on that, that's a positive indicator for invalid results as well. Because people who are

12:21:05 even substantially compromised cognitively in, like,
12:21:09 Social Security disability evaluations do better
12:21:11 than that. It's been proven to be an effective
12:21:17 validity test for people with substantive cognitive
12:21:19 problems.
12:21:19 **Q.** So did Mr. Brockman pass or fail this validity
12:21:22 test?
12:21:22 **A.** He failed it the first time. He failed it
12:21:26 horribly. Then Dr. Guilmette did the same thing.
12:21:32 He then coached him on how to do the test, at which
12:21:35 point he passed it with flying colors, which proves
12:21:39 that he could have passed it the first time, but for
12:21:43 the coaching that Dr. Guilmette gave him to
12:21:46 basically -- for anybody who is savvy about
12:21:51 interactions will pick up on, "Oh, I should have
12:21:54 passed this test."
12:21:55 **Q.** So in total, when Dr. Guilmette was evaluating
12:21:58 Mr. Brockman in July of this year, what was the
12:22:01 ratio of passed validity test -- in your opinion,
12:22:05 passed validity tests versus failed validity tests?
12:22:08 **A.** Yeah, they're looking at the free-standing
12:22:11 tests and the embedded tests in a fair manner, there
12:22:14 is probably -- I believe there's nine of them.
12:22:19 Let's see -- because there was the TOM, which was
12:22:22 another free-standing test that he passed, although

12:22:24 he didn't give the whole test. Dr. Guilmette didn't
12:22:28 give the entire test, so it's hard to have much
12:22:31 confidence in that.
12:22:32 So there was one, two, three, four
12:22:38 -- five free-standing tests and four embedded ones.
12:22:42 And of those validity tests, Mr. Brockman failed
12:22:47 four of them.
12:22:51 **Q.** Now, what -- in your opinion?
12:22:53 **A.** Yeah, in my opinion certainly.
12:22:55 **Q.** And Dr. Guilmette doesn't agree with that
12:22:58 opinion; is that right?
12:22:59 **A.** No, his report appears to indicate to me that
12:23:02 he believes that they were failed because of genuine
12:23:05 impairment.
12:23:06 **Q.** And on Page 18 -- well, first of all, what does
12:23:09 that indicate to you, and how does that inform your
12:23:13 professional opinion of Mr. Brockman's condition,
12:23:15 the fact that in your opinion he failed four
12:23:17 validity tests administered by Dr. Guilmette?
12:23:22 **A.** Four positive -- even in the context of nine
12:23:27 validity tests is pretty striking. It's not like
12:23:32 just one was failed and you think, "Okay. Maybe it
12:23:34 was just an fluke," but four were failed.
12:23:40 And keep in mind, each test, in and
12:23:42 of itself, is designed to be rarely failed. And it

has cutoffs set for cognitively impaired people, because we're dealing with dementia possibility here, that makes them very low in their false positive rates. So when you combine four of them together, the probability of them all being false positives is pretty nil.

There's research showing that when you've got multi-validity test -- there's five different studies since 2000 -- oh gosh, 2009, that show when you've got two or more positive validity test fails in a battery of malingering tests, even up to nine of them in the battery, that's still a positive indicator for not valid tests.

In other words, the rest of the neurocognitive test battery cannot be relied upon as indicia of genuine cognitive functioning.

Q. So does Dr. Guilmette in his report attempt to address the two -- or two to four -- two, if you believe Dr. Guilmette, four if you believe you -- in your opinion, the fails of Mr. Brockman in these validity tests -- does Dr. Guilmette address that and why -- trying to address perhaps why Mr. Brockman failed his tests?

A. Well, he does. And you made a good point in -- in Dr. Guilmette's analysis there were two fails,

and two is enough based upon the research. But then Dr. Guilmette -- it appears to me in reading his report that he's basically saying, "Well, I think those two were failed because he was confused," or "He was too impaired to do them."

So that, to me, appears to be a way to rationalize away the failed results in order to say that the tests were valid.

Q. Does Dr. Guilmette entertain the possibility that Mr. Brockman may have been suffering from some delirium, and that may be why he failed some of those tests?

A. That's a little vague in his report. I know Dr. Agronin's report makes it more clear he believed there was delirium present. Dr. Guilmette raises the issue of, "Well, maybe he's still in delirium."

And I think his latter conclusion was that he has some delirium, but even still he has dementia underneath it and seemed to suggest, "Well, maybe he failed that because he was in delirium."

That was my takeaway from reading his report.

Q. In your review of this test data, do you believe when Dr. Guilmette administered these tests to Mr. Brockman, that Mr. Brockman had any delirium?

12:26:27 **A.** No, I don't believe he did.
12:26:29 **Q.** Why do you have that opinion?
12:26:31 **A.** Well, the other test data. And I -- and I did
12:26:34 review the interviews -- the video of the
12:26:37 interviews. And I agree that the man is acting in a
12:26:40 way that would suggest he could have delirium. He's
12:26:44 changing subjects on them in the middle of
12:26:46 conversation, given non-sequitur types of answers,
12:26:52 but when you look at the test data Dr. Guilmette
12:26:54 actually acquired from Mr. Brockman that day -- or
12:26:58 those days they demonstrate, in fact, that he was
12:27:00 not in delirium.
12:27:03 **Q.** Dr. Denney, what is the Iowa Gambling Test?
12:27:09 **A.** It is a computerized test that uses a deck of
12:27:13 cards -- actually four different decks of cards, and
12:27:16 it's designed to measure a person's risk-taking
12:27:22 tendencies, which is a characteristic of executive
12:27:25 function. You know, people that start having
12:27:28 executive functioning problems oftentimes start
12:27:31 taking greater risks, and have poor judgment and
12:27:34 make bad decisions. And this test is designed to
12:27:40 measure that.
12:27:41 It's a computerized test where you
12:27:42 have to interact with the computer consistently over
12:27:48 -- about 15 minutes, unless you are slow. And in

Mr. Brockman's case, it went 17 minutes.

The thing that's striking about the test is the instructions on it -- the instruction card is a full-sized piece of paper that is single-spaced all the way down, explaining how this test works to the examinee.

Q. What is the point of the Iowa Gambling Test?

A. The point of it?

Q. I should say the objective.

A. The objective is to measure -- the objective for the test taker?

Q. Mm-hmm.

A. Okay, the objective is to choose the deck of cards -- it's a gambling test, and you click on a deck. And it's going to give you a response that either earns you more money, or takes money away from you. You are starting out with a certain amount of money. It's like a slot machine. You took this deck, and you either get money or you lose money.

Well, I take this deck and I either get money or lose money, and then the probabilities are changed for the decks. So a couple decks are losers; right? If you consistently hit these decks, you are going to lose money fast. The other two

decks are relative winners.

One wins at a very small amount on a more consistent basis, and the other deck looks to be like a loser, but when it wins it wins big. So in the long run it's a winner. And so the person -- none of that is told to the person. They have to figure this out on their own which deck is a good deck to choose. And you start out with a certain amount of money, and the goal is to make more money, or at least not lose much money.

Q. When did you administer this test to Mr. Brockman?

A. I did not administer it.

Q. Who administered it?

A. Dr. Guilmette.

Q. Can we put on the screen the -- did you review the test score that resulted from this test?

A. Yes, I reviewed the raw test data from Dr. Guilmette.

MR. COREY SMITH: And we're going to mark this as 127, Your Honor.

THE COURT: Okay.

MR. COREY SMITH: This is from Dr. Guilmette's data.

THE COURT: Any objection?

MR. LOONAM: No objection.

THE COURT: 127 is admitted -- I'm sorry.

MR. COREY SMITH: No, I'm sorry, Your Honor. Thank you.

Q. Dr. Denney, what do these test scores in the Iowa Gambling Test administered by Dr. Guilmette tell you about Mr. Brockman?

A. Yeah, let me -- let me orient the Court to the document first. We see the raw score column there. We see those translated into T-scores. Those are normative scores, and then the percentiles next to those scores for demographically corrected -- you see that above that a column that says demographically correct? That's for age and education.

Then the next column over US Census match is based upon a broad US Census data -- not the US Census of course, but a sample of participants that mirror the US Census data in age, ethnicity, race -- things like that. And so -- so we can compare how Mr. Brockman performed, not only to other men his age and education, but also to the general population of the country.

Down at the bottom are the exact

performances for each deck. And we see here for -- and the net total -- I'll explain that. That's for the first part of the test, second 20 percent of the test. So the test, over time, is broken into sections. It just measures how he changes over time.

You'll notice all of those T-scores for the net one through five are -- range from 43 at the lowest to the high of 54. And if you recall, T-scores are normed with a mean of 50, and a standard deviation of ten. So anything above 40 is norm. It's within one standard deviation. You can see that reflected in the percentile scores next to that.

So the lowest score was a 43, which would be in the low average range with a percentile of the 24th percentile. That's still normal for his age and education for an 80-year-old man.

Then we look at the decks and you'll see the performance for each of the decks is above the 16th percentile. The 16th percentile is the demarcation line between one standard deviation below the mean and below. So anything 16th percentile and above is within normal limits.

And if you compare then to the US

12:32:34 Census match, his scores also are perfectly normal
12:32:37 throughout this entire test.
12:32:38 **Q.** So what does that -- these test results tell
12:32:41 you about Mr. Brockman?
12:32:42 **A.** Well, they tell me that he's got pretty decent
12:32:47 risk-taking behavior. It's not too bad. Judgment's
12:32:51 not too bad. But more importantly, in context of
12:32:54 this questioning it tells me he's not in delirium,
12:32:57 because this is a 17-minute long test.
12:32:59 And remember, the hallmark of
12:33:01 delirium is variable arousal; right? A person's
12:33:05 with you, and then they're not. If he was really
12:33:10 delirious, he would start this task and then pretty
12:33:12 soon stop and say, "Why am I doing this? What are
12:33:16 we doing here?"
12:33:18 He would not be focussed and be
12:33:20 able to perform this task normally. It's just
12:33:23 impossible. So not only this, there were other
12:33:25 tests, too, in the battery that suggest -- even if
12:33:29 somebody performs poorly, if they can stay on task
12:33:32 for that period of time it tells you that they're
12:33:35 not in delirium.
12:33:36 **Q.** When did Dr. Guilmette administer this test?
12:33:39 **A.** Well, this was July -- I believe it was July
12:33:45 examination. I don't remember exactly which day it

12:33:47 was.
12:33:47 **Q.** Right. So now let me ask a couple questions
12:33:49 about Dr. Guilmette's October examination of
12:33:53 Mr. Brockman. Did you review that test data as
12:33:55 well?
12:33:55 **A.** Yes, I did.
12:33:55 **Q.** And I want to ask you about a test that we've
12:33:58 talked about earlier, this Rey-15 Test, the one that
12:34:01 you administered, and I guess Dr. York administered,
12:34:07 Dr. Guilmette administered this one as well?
12:34:08 **A.** Well, yes. Dr. York did not administer the
12:34:12 recognition portion. She only used the first part
12:34:15 did --
12:34:16 **Q.** With the A, B, C?
12:34:17 **A.** Yes.
12:34:18 **Q.** So how did Mr. Brockman do on this test for --
12:34:21 for Dr. Guilmette?
12:34:24 **A.** Well, he failed it, number one. The -- he
12:34:32 performed -- he -- when you look at the just the
12:34:36 free recall part of it, he got six of the items
12:34:39 correct out of the 15.
12:34:40 **Q.** So we have -- just a minute. We have
12:34:42 Dr. Guilmette's test data from this test we'd like
12:34:45 to put on the screen and mark for identification as
12:34:47 128?

12:34:48 THE COURT: Okay. Any objection to 128 being admitted?

12:34:51 MR. LOONAM: No, Your Honor.

12:34:53 THE COURT: Without objection, 128 is admitted.

12:34:56 MR. COREY SMITH: Thank you.

12:34:57 THE WITNESS: There you see on the screen Mr. Brockman's performance on this 15-item test. You probably remember what the diagram looks like.

12:35:07 And he got A, B, C and 1, 2, 3, and then there's another little mark down there that I'm sure Dr. Guilmette will have to explain, but is an intrusion. It's an extra item. It may be a three, I don't know. Nonetheless, he got 6 of the 15 items. And so, for this -- for an elderly group with cognitive problems, this would be a pass, but then you need to look at two different things.

12:35:39 One is the recognition portion, but also this performance compared to other visual memory performances during the evaluation. Because remember, this is a very simple visual, memory task.

12:35:53 **Q.** So what other tests are you talking about -- comparing this to what other tests?

12:35:59 **A.** Well, Dr. Guilmette also administered the

RBANS, R-B-A-N-S, which stands for Repeatable Battery for the Assessment of -- or Neuropsychological Assessment -- something like that. Nonetheless --

Q. We have that test sheet.

MR. COREY SMITH: Like to mark as 129, Your Honor.

THE COURT: Any objection to 129 being admitted?

MR. LOONAM: No, Your Honor.

THE COURT: Without objection, 129 is admitted.

MR. COREY SMITH:

Q. You were about to compare these two tests administered by Dr. Guilmette?

A. Yes. I don't mean to be inappropriate, but I want the Court to understand the RBANS is a small battery of cognitive tests that go together, and they measure verbal learning, visual learning and retention, verbal retention, visual/spacial skill, the ability to understand geometric lines, as well as copy a figure and remember that figure over time.

That's this portion over here is the figure recall portion. You'll see the diagram at the top is the stimulus card that the examinee

looks at, and they copy the figure. The first time they see that design, they're instructed to actually copy the whole thing.

And then you go through -- then it's taken away. Then you go through different tasks, verbal learning tasks -- or not so much verbal learning, but use the speed of processing and attention-concentration sort of tasks, and then you come back to the verbal recall and that sort of thing. Then near the end of it about -- I would say about seven to ten minutes later you ask him to draw that figure again from memory.

So this is after -- roughly 10 -- 9/10 minutes of distracting activities. Then he pulls this out of his memory in whole cloth. He's able to get several points related to this geometric figure. You can see the resemblance, the rectangle, cross, and a little bit of triangular work there. When you compare that -- ability to draw there after let's say eight minutes of distracting activity, and you compare that to his performance on the Rey-15, in which -- which is strikingly simple and there is no distracting delay -- it's an immediate performance -- those two don't make sense.

If he can do this on the Rey figure

12:39:10 recall, he should have aced that 15-item test.
12:39:14 **Q.** And the fact that in your opinion these two
12:39:17 tests administered by Dr. Guilmette in October are
12:39:20 inconsistent, what does that tell you about
12:39:23 Mr. Brockman?
12:39:25 **A.** Well, that his test data are not a valid
12:39:28 reflection of his genuine ability. When a person is
12:39:33 attempting to exaggerate cognitive deficit, they
12:39:37 don't really know for sure what they're doing.
12:39:40 They're somewhat shooting in the dark. They perform
12:39:42 more poorly on some tests, but then do a little
12:39:45 better on other tests, and variability in there --
12:39:48 oftentimes that doesn't make any sense.
12:39:50 And so, that's what we see here.
12:39:52 We see him performing better on a more difficult
12:39:55 task than he did on an extremely simple task. That
12:40:02 tells me he's not applying appropriate task
12:40:06 engagement in this neuropsych test battery, which
12:40:10 results in not valid test findings.
12:40:12 **Q.** So now -- just one last set of questions,
12:40:18 Dr. Denney. There's been a lot of evidence so far
12:40:21 in this hearing about whether or not what the status
12:40:24 of Mr. Brockman's memory is over the time frame that
12:40:27 he has been given these tests. Did you have the
12:40:30 opportunity to review that data and chart it out for

12:40:33 the Court?
12:40:35 **A.** Yes, I did. And the reason I did is because --
12:40:39 as you suggest -- his memory concerns have been a
12:40:42 major part of the notion whether he's competent
12:40:46 enough or not to assist counsel. So I wanted to
12:40:52 look at his summary memory indices across time to
12:40:52 see how that looks.
12:41:00 MR. COREY SMITH: And with the
12:41:01 permission of the Court, we'd like to show that
12:41:01 chart.
12:41:01 THE COURT: Sure.
12:41:02 MR. LOONAM: Your Honor, I'm sure I'll
12:41:03 have no objection -- I see. The -- at the bottom.
12:41:07 I see. Okay.
12:41:09 THE COURT: Is that going to be exhibit
12:41:10 --
12:41:11 MR. COREY SMITH: 130, yes, Your Honor.
12:41:13 THE COURT: Okay. Any objection to
12:41:14 Government's 130?
12:41:15 MR. LOONAM: No, Your Honor.
12:41:16 THE COURT: Okay. Without objection,
12:41:17 Exhibit 130 is admitted.
12:41:20 MR. COREY SMITH: Thank you, Your
12:41:21 Honor.
12:41:21 **Q.** Dr. Denney, can you please describe for the

Court what you charted out in your graph here?

A. Yes, I took the index -- the best -- the most summary index score from each of the test batteries. I did not take an individual subtest because they vary more, and I did not want to in any way look like I'm cherry picking. I took the primary memory index from each evaluation.

Dr. York administered a portion of the Wechsler Memory Scale IV for -- it's called the older -- older-adult battery. And I took the summary index for his delayed recall of verbal and visual material, the LMVR. I did that -- because she administered that through all three exams. And then I placed the standard score here underneath the label. Then I put the percentiles in there.

Now, not everybody that evaluated Mr. Brockman used the exact same tests. However, those tests are all applied to norms, and produce standard scores. All of them have the same types of standard scores, so we can compare them. And of course we can compare percentiles across the tests, and that will tell us how he performed in the memory domain across time.

So I've explained the memory index from Dr. York's evaluation. As I noted -- and then

12:43:14 the one, two, three -- so we have March '19,
12:43:18 December '19, and October 2020, and then we've got
12:43:22 my first evaluation from May 2021, during which I
12:43:27 administered the NAB® Memory Module, and that has
12:43:31 one summary indicator.
12:43:33 All of the little subtests in the
12:43:36 Memory Module have one index score. That's what I
12:43:40 used. It's the most stable score. It was an index
12:43:44 score of 58.
12:43:47 Then I looked at Dr. Guilmette's
12:43:48 July test data, and he administered the RBANS, which
12:43:52 is that small neurocognitive battery. In the RBANS
12:43:56 is a delayed memory index score, which takes into
12:44:02 consideration a -- an examinee's ability to remember
12:44:05 information after distracting delays. So that's
12:44:09 ability to remember information.
12:44:10 I use that index for
12:44:14 Dr. Guilmette's examinations, because he used the
12:44:17 RBANS for both of his examinations. In my last one
12:44:21 there on the right, my October 2021, I used the same
12:44:25 NAB® Memory Module index as I used the first time.
12:44:28 So all of these are summary indices
12:44:31 scores for overall memory or delayed memory. You
12:44:35 can see, comparing across time, those scores and the
12:44:43 percentile scores at the bottom that correspond to

each of those scores. They are all at one percent -- the first percentile or below the first percentile.

Then I graph those percentile scores. And you'll notice the axis there going from 0 to 16. I chose 0 to 16 because anything below the sixteenth percentile is the impaired range, you know. Above the sixteenth percentile is considered normal, and technically go all the way up to 100, but then the chart would be, you know, kind of confusing.

And so I just focused on the impairment range -- or possible impairment range that we're looking at. And you can see strikingly across this figure that Mr. Brockman performed at the lowest ranges possible basically on all of these memory tests starting in March of 2019, through October 2021.

Q. So what does that -- this analysis you've just described for the Court, what does that tell you about Mr. Brockman?

A. I see no clinical course, okay.

Q. What does that mean?

A. Every -- every neuropathology has -- every pathology has a clinical course -- a natural course.

How does the condition evolve over time? I mentioned this earlier, with a neurodegenerative disease, it has a standard pattern. It starts mild and then gets worse over time.

With Mr. Brockman, we see devastatingly severe scores from the get-go. He doesn't show this -- what we would expect if his condition was getting worse over time, we would see a normal curve that we would expect for a neurodegenerative disorder. We don't. We see a flat line on the basement from the very beginning.

Q. And the memory scores you have to the far left, Dr. York 3/2019 and 12/2019, are those scores taken from the tests contemporaneous with the speeches and the depositions that we talked about earlier today?

A. Yes, that's true. Exactly.

Q. So do you, in your professional opinion, believe those are real scores?

A. Well, they're real scores, but not genuine -- genuinely reflecting his genuine ability. You see what I'm saying?

Q. Yeah.

A. They're real scores and they did occur. Dr. York administered them, but they don't reflect honest to goodness real ability, because they don't

correspond to what we see in the videos.

Q. So in your opinion, and looking at all of this data, including -- not just the test data in your analyses, but these real-world speeches and depositions and Mr. Brockman's conduct outside the examination room, what is your professional opinion about whether Mr. Brockman is competent to stand trial in this case?

A. It's my professional opinion that there's no way that he had genuine impairment like this early on. And it's my opinion that he has been exaggerating and malingering from the very beginning. And looking at the total information in this case, I believe that he is continuing to exaggerate, and that he is competent to stand trial.

Now, he may have mild cognitive impairment. He may even have cognitive impairments to the point that you could say it's mild -- earliest stages of mild dementia, but even with that, in my professional opinion, Mr. Brockman is competent to proceed. If he chooses to cooperate with his attorneys, he can do that.

MR. COREY SMITH: Thank you, Dr. Denney. I have no further questions for Dr. Denney, Your Honor.

12:48:54 THE COURT: What we'll do, everyone, is take a break until 1:45. I have another matter to take up right now, but you can leave -- just like yesterday, leave everything in place. Won't be a problem, but we'll start back up at 1:45.

12:49:09 MR. COREY SMITH: One item, Your Honor. By agreement, we have a witness that we're going to take out of order before we start the cross with Dr. Denney, just because he has to leave the country, if that's okay with the Court.

12:49:19 THE COURT: Not a problem.

12:49:20 MR. COREY SMITH: It's not another doctor.

12:49:22 THE COURT: Not a problem at all. We'll take that witness up at one forty five.

(WHEREUPON, THE PROCEEDINGS WERE RECESSED AT 12:49 P.M.)

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C E R T I F I C A T E

I hereby certify that pursuant to Title 28, Section 753 United States Code, the foregoing is a true and correct transcript of the stenographically reported proceedings in the above matter.

Certified on 11/17/2021.

Sean Gumm, RPR, CRR

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